			1 - For State Registrar	State of M	arylan		artment			ind M		giene Reg. No.	0.5	1350	- Carlos de Carl
-	Physic	an	Decedent's Name (First, Middle, La	/							Date of Dea Month	ath Day	Year	3. Time of Deat	n
	/Medi		ISIDOR ZELLER								April	10	2006	1:00 P	М
)	Examir	ner	4a. Facility Name (If not institution, giv						Location of	f Death		4c. Co	unty of Death		
			11801 Rockville P					kvi1					ntgomer		
4	Funeral		5. Social Security Number 6. S 219.32.3258	ex 7. Ag Min 2 ☐ F	- '	ast birthday) Yrs.	If Under Months	Days	Hours 2	Min.	8. Date of Birtl (Month, Day	r, Year)	9. Birth	place (State or Fore ntry)	эign
	Director		Usual Residence of Decedent		93	113.					May 28	, 191	2 Gerr	nany	_
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Lim	nils
	Mary	ţo	Maryland Montgon	erv	Ro	ckvill	e							1 ⊠ Yes 2□	No
	h the	re	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Cou	ntry?	
	1h wil	a C	11801 Rockville H	ike, Apt	#1509		20	852				U.S	. A .		
	ep	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. \	Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,		
98	or it	y F.	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give			1 ☐ Yes 2		Specify:	, 1 00110	110411, 0(0.)		ecify: Wh:		
g	within 72 hours after deeth with the Maryland ene. then "naturel", or items 23e or 28e-1 show ta Madical Examinar must be notified at	p	3 Widowed 4 Divorced	Year or Dates:											
7	"net	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	k done d	uring most	of worki	ng	16b. Kind	of Business/In	dustry	
72	withii ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4or	5+)		esper		,			Reta	o i 1		
0	be filed within 72 hours after deeth with the Marylan Ital Hygiene, id other then "naturel", or items 23e or 28a-f show event, Ita Modical Examiner must be notified at		17. Father's Name (First, Middle, Last,				coper	0011	18. Mother	r's Name	(First, Middle,				
an	id be ental ked c	To Be	Joseph Zeller						Dora		ngel				
37	shound M	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	ng Address	(Street a			l Route Numbe	r. City or To	own. State. Zi	Code)	_
ž	nd 2		Gulalai M. Daoud	/Wife										D 20852	
ē,	S 1 a se Heri		20a. Method of Disposition			lace of Dispo	sition (Nam	e of			ate		ion - City or T		
Ĕ	Page Timent		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			norah		,		4/12	/2006	Rocky	ille.	Maryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be fill Department of Health and Mental Himportent: if Item 27 Is marked oth eny finjury or other treumatic even once.		21. Signature of Funeral Service Licer		1.	22	Name and	d Addres			RAL HOM			J	
Ö	\$9E \$ 8		Naman A	Keram	Tu	1 1	INES- 1800	KLNA New	LLDI E Hamps	ONE:	RAL HOM	E, INC Silver	Sprin	g, MD 20	90
8760,	death certificate be executed to a strending physicien and se attending physicien and for use as the buriar-transit	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Prostat Due to (or as b. Atrial Due to (or as c. Due lo (or as d.	a consequ Fibri a consequ	uence of): .llatic uence of):	on								
O. Box 6	death certifii e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre					23d	. Date of deliv Month	ery Day Year	
S, P	es tha igned be det	by P	Part II. Other significant conditions of	ontributing to death b	ul not resu	Ilting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?	,
Zd	w require been si should t										1 🗆 Y	es 2 🔼 N	lo 3 🗆 Prol	oably 4 Unkno	wn
of Vital Record	The la ete hes page 2	Completed								_	24a. Was autop perfor 1 Yes	med?	4b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings availa impletion of cause	ble of
Žį.	ician sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				14.		of Death	(Check only o	ne)			
ot	Physician: this certificant	ို	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 L Inpatie		ER/Outpatien			4 1401		ne 5⊠ Resid			fy)	
L C	fing Afte fune	lon	1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe h	ow injury o	ccurred		
Division	to the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At hor c. (Specify	me, farm, stre	M eel, factory,		/es 2□N		28f. Location (S City or Tow	itreet and N n, State)	umber or Run	al Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edicai	29a. Certifier (Check only one) 1 ☆ Certifying Ph 2 ☐ Medicel Exam	ysician: To the best niner: On the basis o and manner sta	f examinati	wledge, death ion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the co	ause(s) and date and pla	d manner as s ice, and due t	stated. o the cause(s)	
	To the To the Complet	Σ	29b. Signature and title of certifier		•	MID		License		<i>(</i> -			igned (Month,		
			Hypanol	maria	7	11.0	-	0-0	276	60		April	11, 2	UU6	
	4			MD, 11119	Rocky	23a) (Type, l	Print) Pike,	Sui	te #G	-100	, Rocky	ille,	Mary1	and 2085	2
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Pegislr		ure	alle .								

State of Maryland / Department of Health and Mental Hygiene [] 1 - For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April Day 2006 Year Physician 9 Sara Patricia Zook 5:27 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3250 Karen Drive Chesapeake Beach Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2137 F 134-42-9510 Yrs. Director 55 24,1950 **England** Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State r than "natural", or Itama 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No MD Director Calvert Chesapeake Beach the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3250 Karen Drive 20732 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene importent: if item 27 is marked other than "natural; or its, eny injury or other traumatic event, the Medical Example once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Coflege (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Frazer Llewellyn Maisie Annie Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank D. Zook (husband) 3250 Karen Drive Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 14, 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Lee Crematory 2006 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Properal Service Lanse 8125 Southern Maryland Blyd. Owings, MD **G**bff Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or commerciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC LUNG Physician Month 5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and dedecred for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 19€Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1☐ Yes 2☐ No 2 No 1 TYes tel or Attending Physician: T
:s after death.
el Director: After this certificate
ed in by the funeral director, pa 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Be Hospitat: Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerei I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 40370 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 10845 Town Center Blyd, Dunkirk, MD 20754 Wisniewski, M.D. 31. Date filed (Month, Day, Year) 32. Registras Signature State

DHMH 17 Rev 1/2001

Registrar

			For	State of Mary					_		o o o	
			1 - State Registrar		(Certifica	te of De	eath		Reg. No.	JUb	13503
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Khabi	- a	shsh	akus		2. Date of De Month	ath 26	2014	3. Time of Death 3: 45 p M
	Examin		4a. Fecility Name (If not institution, give	street and number)				cation of Deat	h		ounty of Deeth	
			Herry Mevica		-	16		nora				
	Funeral Director		N/A	7. Age (ir	yrs. last birth	rs. If Und Months		f Under 24 Hrs Hours Min.		Year)		plece (State or Foreign ntry) YLAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location						10d. Inside City Limits
	Mary!	ŏ	MD. N/A		BALT	IMORE						1∭Yes 2□No
	the 1	Director	10e. Street and Number			10f. 2	Zip Code			10g. Citize	n of What Cou	ntry?
	h with	O I	3603 EVERGREEN AV	7Е.			21206			US	SA	
	deati	Funeral		12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Dec		anic Origin? (S	Specify Yes or No to Rican, etc.)		. Race - Ameri Black, White,	
920	d within 72 hours after death with the Maryland Jone. r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			_	Specify:	to rican, etc.)		pecify: BL	
2-0	72 ho natur	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. (Decedent's Us	sual Occupation	on and most of wo	rkina	16b. Kind	of Business/In	ndustry
Maryland 21215-0036	d within giene.	Completed	Elementary/Secondary (0-12) — 0 —	College (1-4or 5+) -0-		life. DO NOT	use retired)	ing most of wo	, may			
Pu	be filed ttal Hygid of other avant, I	Be C	17. Father's Name (First, Middle, Last)				18	B. Mother's Nar	me (First, Middle	, Maiden Si	ımame)	
Val		인	KHABIR ASHSHAKUR					MELIS	SA ELDRI	DGE		
Jar	ges 1 and 2 should t of Health and Mer if item 27 is marks or other traumatic		19a. Informant's Name/Relationship (Ty	•		_			ural Route Numb	_		
	l and lealth im 27 her t	1 3	MELISSA ASHSHAKUF			Disposition (N		AVE.	BALTIMOR Date		RYLAND	
Baltimore,	Pages nent of H int: If its iry or of		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R	emoval from State	cemetery	, crematory or	r other place)					
Itir	artmen ortant: injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service License			CREMAT(-2006 DD FUNER			MARYLAND
Ba	permit. Departm Imports any inju		21. Signature of Parties Service Excens	() Chia	.е.)							YLAND 21217
			23a. Pert1. Pater the disease, or compli	ications that caused the	death. Do no	-					E, PAR.	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	() (P		1 1	1	22	6		Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a co		1 ma	Dr. T	$\gamma \prec$	3 Will	<u>/</u>		1 days
п	Examiner		Construction that the state of the same state of	Kepira	torn	0,51	1000	Vyn	drom!	V		7 Jays
	B ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequend o):						- 1
10	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Lepos is								1 Jugo
,09/	be executed icien and burial-transit	calEx	resulting in death, cast	Due to (or as a co	nsequence of):						
687	9 %	edica		J								
9 X	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be delached for use as it	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p	regnancy					23	d. Date of deliv	verv
Вох	death a atter d for u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		3 ☐Ectopic 5 ☐ Other (Month	Day Year
O.	that the de led by the a detached i	hys	9 Unknown	9□ Unknown								
S, D	ires tha signed d be det	by P	Part II. Other significant conditions con	ntributing to death but no	ot resulting in	the underlying	cause given	in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ord	w require been sig should t	ed	Hypuhatra	mia					10	Yes 2□	No 3□Pro	bably 4 Unknown
Records,	e law r has be je 2 sh	Completed	Hype 914	Imia)					24a. Was	psv	24b. Were auto	opsy findings available ompletion of cause of
æ		E O							perfo 1 ☐ Yes	ormed? 28 No	death? 1 ☐ Yes	
Vital	sician: certifica rector, p	Be (25. Was case referred to medical examiner?					6. Place of Dea	ath (Check only o	one)		
of	Physi this c	ည	1 Tes 2 No	fospital:	2 EP/Out				fome 5 Resi			fy)
n C	ding Ph th. After th funeral	lon	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Ti	ury	28c. Injury al Work?		28d. Describe	how injury	occurred	
isic	Attending Physician: r death. sctor: After this certific by the funeral director,	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home, farr	M street facts		s 2 No	28f Location /	Street and	Number or But	al Route Number,
Division	i ji g	Certification;	4 Homicide determined	building, etc. (S	Specify)	ii, stieet, iacti	ory, ornog		City or To		10///00/ 0/ //0/	ar reade ramber,
	To the Hospitel or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of m ner: On the basis of exa and manner stated	y knowledge, amination and	death occurre for investigation	ed at the time, on, in my opini	date and place on, death occu	a, and due to the urred at the time,	cause(s) ar	nd manner as s lace, and due t	stated. to the cause(s)
	o tha vithin o tha omplé	Med	29b. Signature and title of certifier			2	9c. License n	umber		29d. Date	signed (Month,	Day, Year)
	- s - o) ()	Megrator	borst	_	Dus	7175	•	4	1261	06
	\		39. Name and address of person who co	empleted cause of death	(Item 23a) (1	ype Print)	5	113	4			
	1		Mercy medical	Centr 30	1 ft	PauL	YL.	Balt	honore	m	0 21	212
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	alle !						
	Registr	ar	2000 A 1 2000	Free S. A.	S A STATE OF	N. W.						

06-02663 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene James Brailsford 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) James J Brailsford, Jr. James Anthony Brailsford 2. Date of Death Physician/ Time of Deatl Month Day April 19, 2006 1256 hrs Medical Examiner Anthony Brailsford Jr. James 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Baltimore Good Samaritan Hospital 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Months Days Hours Min Director Country) MD 1 XM 2 F 57 Yrs 03 12 49 214-68-2931 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a. State 10h County 1X Yes 2 No items 23a or 28a-f show ust be notified at once Baltimore NA MD after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country U.S.A. 21215 5708 Jonquil Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White etc 1 X Never Married 2 Married 2 X No Yes Black 3 Widowed Give Year 1 Yes 2 No specify: Divorced Specify mit. Pages I and 2 should be filed within 72 hours afte partment of Health and Mental Hygiene portant: If item 27 is marked other than "natural", tury or other tranmarie event, the Medical Examiner ury or other tranmarie event, the Medical Examiner. ۾ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pest Store 21215-0036 Co-Owner 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Anthony Brailsford Edith Mack Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ Baltimore, MD 5708 Jonquil Ave, Baltimore, Md 21215 Edith Brailsford-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify 4/22/06 Randallstown, Memorial Park 2 Sk nature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death Cardi myorathy associated with end-stare renal disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exam (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and Physician/Medical item#1,23a,PII,27,perME,2856,6/7/06 TI item#1,perME,2856,6/14/06 TI X UNPENDED AMENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Dav Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ ı Yes 2 No 3 Probably 4 ✔ Unknown Aortic valve incompetence with healed endocarditis; chronic Completed peen 24a Was an 24b. Were autopsy findings available pericarditis autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Hospital: Other_a [2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other Inpatient 1 🗸 Yes After 1 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No I Director: Pending 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started To the 1 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mi O.C.M.E. April 20, 2006 30. Name and address of person who completed cause of death (Item 23a)

OCME 2006

Registra DHMH 17 Rev 1/2001

State

Ling Li, MD

31. Date filed (Month, Day, Year)

0

Assistant Medical Examiner

32 egistrar's Signature

111 Penn Street, Baltimore, MD 21201

			1 _ State	partment of Health and M ertificate of Death		4000 13303
			Registrar 1. Decedent's Name (First, Middle, Last)	orimodic or bodin	2. Date of Death	3. Time of Death
	Physicia /Medic	al	Ronald J. Brown		April 2	6 2006 9:10 PM
	Examin		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	4	c. County of Death
B	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 20 F 5) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 03 03 19	9. Birthplace (State or Foreign Country)
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. fnside City Limits
	e Mary	Director	MD N/A Bal-	timore		1 Sex es 2 □ No
	th with th	ai Dire	979 North Hill Road	10f. Zip Code 21218	10g. C	Citizen of What Country?
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show if item 27 is marked other then "natural", or item 27 is marked owent, Ire Madical Examinar mail to incilified at	/ Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Married 1 Yes Give	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 (♣4) Specify: 	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
9	2 hours stural', cal Exa	ted by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Decupation	16b.	Kind of Business/Industry
Maryland 21215-0036	within 73	Completed	Elementary/Secondary (0-12) College (1-40r 5+)	ive kind of work done during most of work a. DO NOT use retired) OHCLE	ing	Security
ام 2	e filed al Hygie other vent, II	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide	en Sumame)
rylaı	should b ind Ments marked umatic e	10	19a. Informant's Name/Relationship (Type, Print). 19b. Mi	Jeanet		
	and 2 selth an n 27 te i		Reginald D. Brown/Brother 97	9 North Hill Ro	ad Balli	More NID 21218
nore	Pages 1 nent of He int: if iter		1 Maurial 2 Comption 2 Removal from State Cometery, C	rematory or other place)		andallstown MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Eacility CNG		
	46244		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart faifure. List only one cause on each line.			Approximate fnterval Between
	Physician		Immediate Cause (Final disease or condition a. Discurrate: intro	Warcolar Coagolation	(DIC)	Onset and Death
	/Medical Examiner		Due to (or as a consequence of): Sequentially list conditions, b. Perforated Stom	ach		1 cay
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	O. a.		2 de un
90,	cate be executed physicien and the burial-transit	il Exar	that initiated events c.			z vilg i
68760,	ificate b g physic as the b	edical	d			
Вох	thet the death certificed by the attending properties as	by Physician/Me	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.O.	et the d I by the etached	Physi	9 Unknown		OG BULLE	of death?
rds,	quires the n signed uld be del	d by	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Division of Vital Records,	: The law requires thet the death certificate be executed cete hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ital		0	25. Was case referred to medicaf	26. Place of Deal	1 ☐ Yes 2 🖫 1 th (Check only one)	No 1 Yes 2 No
of V	Sic all	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim		ome 5 Residence	6 □Other (Specify)
on	Attending is death.	atlon	1 Maturaf 5 Pending (Month, Day Year) Injul 2 Accident investigation		200. Describe flow in	any coodined
Divis	N or Atte after de Directo	Certifications	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pface of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/o and manner stated.			
400	To the within To the comple	Me	29b. Signature and title of certifier.	29c. License number	29d. [Date signed (Month, Day, Year)
	•		>5.7. Sauce Keli M.D.	AT 2438946	-140 Ap	oril 16, 2006
	3		30. Name and address of person who completed cause of death (Item 23a) (Ty SHAHAB TOURSAVAD KOHI 45 Fountain	AT 2438946. In Ridge Circle Ba	llimore 1	1D 21234
	Sta Regist		31. Date filed (Month, Day, Year) 32. Règistrar's Signature	Faith 6		

			State of M	laryland / Department of Health and I	-	-
		_	For State Registrar	Certificate of Death	Reg. N	000010000
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Elsie	Blount	1 1	24, 2006 4 50 A M
	Examin		4a. Facility Name (If not institution, give street and number)	C C 1 11'	2 1	4c. County of Death
	Funeral Director		220.12.4345 10M 2XF	ge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) MD
	aryland show	7	Usual Residence of Decedent 10a. State 10b. County The property of the county of th	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 (∑toges 2 □ No
3	atter death with the Maryland or Items 23e or 28e-f show	Funeral Director	10e. Street and Number 4238 Shamvock A	10f 7in Code	10g. (Citizen of What Country?
	ms 23e	erai	11 Marital Status 12. Was Decedent	t Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - American Indian,
	hours after turat, or Ite	by	1 Never Married 2 Married 1 Yes. Giver Year or Dates:	No 1 ☐ Yes 2 XNo Specify:		Specify: Black
1213-	be tiled within 72 hours after death with the Maryla tal Hygiens that a tal Hygiens do detect than "natural", or items 23e or 28e1's how event, the Modical Examinations to matified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Oth arade Oth Arade NA	16a. Decedent's Usual Occupation (Give kind of work done during most of work form of the control	rking 16b.	altimore city Public Schools
/land /		To Be C	17. Father's Name (First, Middle, Last) John A. Grant	18. Mother's Nar	me (First, Middle, Maid	len Sumame)
Mar	s 1 and 2 should f Health and Mer item 27 is marke other treumetic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ri Ntar 17 Saturn Cow		y or Town, State, Zip Code) MOREMO 21234
D D	0 0	1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or Town, State COUTTONNE MD
Balti	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licensee	Nam and Address Facility Nam York Koaa		
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final	ed the death. Do not enter the mode of dving, such as cardia		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	s a consequence of)!	mia	years
		iner	cause. Enter Underlying	is a consequence of):		
-	ate be executed nysician and he burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as	s a consequence of):		
O. Box 68	ath certifica ttending ph or use as t	Physician/Medi		2 ☐ Fetal death 3 ☐ Ectopic pregnancy at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	uires that the de signed by the a Id be detached t	by	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 \(\sum \) No \(3 \sup \) Probably \(4 \sum \) inknown
Records ,	a law require nas been si e 2 should t	Completed	support, Chronic o	bstructive pulmonary	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
	(D) FT	O	disease ventiator as	Sociated pneumonia	performed 1 Yes 2 2 ath (Check only one)	
ot V	ding Phyeicle h. Atter this cerl tuneral direct	To B	examiner? 1 Yes 2 No Hospital: Inpat 27. Manner of Death 1 Natural 5 Pending (Month, D		Home 5 Residence	
Division	ttending death. tor: Atte the tune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 389 Bloom of It	M 1 Tes 2 No	29f Location (Street	t and Number or Rural Route Number,
N N	itel or A	Certif	determined 200. Flace of it	njury - At home, farm, street, factory, office etc. (Specify)	City or Town, St	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certilic completely filled in by the funeral director.	edical		st of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occ stated.		
	To the vithing To the comp	Me	29b. Signature and title of certifier	29c. License number D = 043.8.3		Date signed (Month, Day, Year)
	X		30. Name and address of person impleted cause of Wilham B. Greenvah, M.	death (Item 23a) (Type, Print) 5505 Hop ki	ns Bayyie	oril 24,2006 en arcle 2,224
	Sta Registi			strar's Signature	mayare	A 6. 467

December March M			1	For State Registrar	State of		d / Dep	eartment of ertificate of	Health a	and M	ental Hyg		6	13507
Social Security Months Comparison of Compa	/Me	dica	1	. Decedent's Name (First, Middle, La	BEA			4b. City. Town	or Location		2. Date of Deat Month	Day	00t	
Usual Residence of Decedent 10c. Cety, Torm or Location Randallstown 10c. Inspector 10c. Cety, Torm or Location 10c. Decode 10c.	Funera	al	5	NORTHWELT NOS	Sex 7	Age (In yrs.	last birthday	RAMO.	ALZST	own		BAL	TUN	place (State or Foreign intry)
Development			1	0a. State 10b. County	altimor									10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Development	th with tha 23a or 28s	Disp	1		Road						1			intry?
Development	ours after dea ral', or items	hy Europe	ny ruite	1 Never Married 2 Married	Armed Force 1 Yes 2 If Yes, Give	es? ∏ No X	.S. 13	_			cify Yes or No- Rican, etc.)	Blac	k, White	, etc.
Development	d within 72 ho giana. er then "netur	omoloto	nanari na	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)	For 5+)	(Giv life.	e kind of work don DO NOT use reti	ne during mos red) -		ng			
Development	should be file nd Mantal Hy marked othe	á	a 1	Mack Mills	Type Print) C	and_	19b. Mai	ing Address (Stre	An	nie	V. G	inn		ip Code)
Physician / Medical Examiner Physician / Medical Examiner Sale Part Entering displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, informatise cause (first one cause on each time. The program of the cause	agas 1 and 2 int of Haalth a t: If Item 27 le			Beverly Ann B. 20a. Method of Disposition ty□ Burial 2 □ Cremation 3 {	rown/ _{mo}	ther	3718 Place of Disp	Collie	er Rd	Ran	dallst	OWN Mo	21 City or T	133 Town, State
Physician Medical Examiner Part Company	parmit. P Dapartma Importan	900G		21. Signature of Funeral Service	nsee		2	22. Name and Add	ress of Facili	ity Cha	atman-	Harris	Fu	neral Hom
1 Inpatient 2 T-R/Outpatient 3 DOA Survival Bloom 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2bb. Ti	be axecuted icien and icien and purial-transit	al er	cal Evaluate	or near failure. List ony immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	r as a conseq	uence of):	_						Interval Between Onset and Death
1 Inpatient 2 T-R/Outpatient 3 DOA Survival Bloom 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2bb. Ti	tha daath cart by the attending achad for usa	M/doioion/M	Ilysician vin	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birt 4 ☐ Pregnar	h 2∐Feta ntattime ofd	I death 3		псу					
1 Inpatient 2 T-R/Outpatient 3 DOA Survival Bloom 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2bb. Ti	equiras that on signad b	1	בֹּל בֹּל	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the	underlying cause	given in Part	l.				
1 Inpatient 2 T-R/Outpatient 3 DOA Survival Bloom 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2bb. Ti	n: Tha law raicata has bei				X 01524	_					autops	y ned?	prior to co seath?	ompletion of cause of
27. Manner of Death Thattural S Pending investigation	ysicla nis carti diracto	0	ם	examiner?	Hospital: 1 🔲 Ing	patient 2.7	■R/Outpatie	ent 3 DOA)thos:				er (Speci	ufy)
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29b. Signature and due to the cause of death (Item 23a) (Type, Print) CLIFFIND FABERMO 540 (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	r Attending Pl ar death. rector: After the			1	(Month,	Day Year)	Injury	M 1	Yes 2	No	Bf. Location (St	reet and Numb		ral Route Number,
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLIFFIND FABERIND 5407 0 LOVRTRDAG, RANDALLSTOWN MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Hospital of the hours aft Funeral DI aly filled in			(Check only 2 Medical Exa	nvsician: To the b	est of my kno	wledije, des	th oppured at the	time, date ar	nd plane, a	ort due to the re	trinoidal most com	TRAF 35 I	Blated.
State March 1997 Constitution of the state	To the within 2 To the compla	No.		Unitely	and manne	r stated.		20a Lino	nca number		1	Od Data signa	1 /1/2-15	O V
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	/			30. Name and address of person who	completed cause	of death (Item	n 23a) (Type	O D I	1249	70		ARRIL	. 22	2007
Registrar MAY 0 1 2006 May 10 10 10 10 10 10 10 10 10 10 10 10 10				CLIFFIND FABE 31. Date filed (Month, Day, Year) MAY 0 1 2	25/10 5 32/Reg 006	gistrar's Signa	LO CV	URT RDI	90,00	9201	ALLST 0	IMM, M	DAR	YLANO

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Marie Blevins	State of Maryland / Department of Health and Mental Hygien
	, , , , , , , , , , , , , , , , , , , ,

	1- For State Registrar	Ce	ertificate of	Death		Reg.		do Ijouc	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,					2. Date of Death Month D April 25, 200	lay Year 06	3. Time of Death 0809 hrs	
	4a. Facility Name (if not institution, RT.152 & Hess Road	give street and number)	4	Fallston	r Location of Deat	h	4c. County of Harford	Death	
Funeral Director	215-29-2993	5. Sex 7. Age (In yrs. 1 M 2 F 1	last birthday) Yrs.	If Under 1 Year Months Day				9. Birthplace (State or Foreign Maryland Country)	
eath with the Maryland items 23a or 28a-f show any sat be notified at once.	Usual Residence of Decedent 10a. State 10b. County Maryland Harf		y, Town or Locati Prest Hil	1				10d Inside City Limits 1 Yes 2 No	
ith the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 2203 Byton Ct	•		10f. Zip Code 21050		10g.	. Citizen of What Country? USA		
	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divor	12. Was Decedent Ever in larged Armed Forces? 1 Yes 2 No reed If Yes, Give Year	If Ye		spanic Origin? (S n, Mexican, Puerto specify:		14. Race - White, Specify: V		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If iten 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grade completed) College (1-4 or 5+)	16a. Decedent	t's Usual Occupa	ation (Give kind of e. DO NOT use ref	tired)	6b. Kind of Busi Iealth (ŕ	
21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medical	Kenneth Norman	Blevins	,		18.Mother's Nam Susan	e (First, Middle, Mai (nmn) F	den Surname) Ricketts	5	
ore, MD 2121: Stand 2 should be file of Health and Mental H If item 27 is marked her traumatic event, To Be	19a. Informant's Name/Relationshi Susan Blevins	Mother	1214 V	an Bibb	er Rd.,	Rural Route Number Edgewood,	Maryla	and 21040	
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med To Be Comp	20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other Spe	Removal from State Oa	Place of Disposi crematory or oth K Grove hurch Ce	Baptist	04/			ity or Town, State Maryland	
	21. Signature of Funeral Service L Stephen A. Hugh	es (per DVR)	13	ame and Addres	sbury Ro	Comas Fun ad, Abing	don. Ma	ryland 21009	
Physician /Medical \(\frac{1}{2}\)	23a. Part I. Enter the disease, or c failure. List only one cause o Immediate Cause (Final disease or condition resulting in death)	n each line. a. Multiple Injuries		e mode of dying	i, such as cardiac (or respiratory arrest	, shock, or hear	t Approximate Interval Between Onset and Death	
er er	Sequentially list conditions,	b. Due to (or as a consequence b.					-		
ted I msit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence				·-··-			
frate be executed froate be executed g physician and the burial - transit	UNPENDED	d. X AMENDED item#21	,perFH,	3 855,5/ 1	/06 TT				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transicompleted by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unkn	4 Pregnant at time of o	2 Fet	al death 3 ner (Specify)	Ectopic pregn	ancy	23d. Date of d Month	elivery Day Year	
P.O. I es that the igned by the detached I by Ph		ons contributing to death but not	resulting in the u	nderlying cause	given in Part I.			ute to the cause of death? Probably 4 Unknown	
						24a. Was an autopsy performe	pri ed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No	
tal ician: certif rector,	25. Was case referred to medical examiner?	Hospital:	J=0/0 : ii :		Other Nursi				
n of Vi ing Physi After this funeral din	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pagetin	28a. Date of Injury	ER/Outpatient 28b. Time of Ir 0800 hrs	njury 28c. Inju	ury at Work?	ng Home 5 Re 28d. Describe how Driver auto au			
Division or spital or Attending tours after death. neral Director: After filled in by the function of the function or the filled in by the function or the filled in by the function or the fu	2 Accident Suicide 6 Could determ	igation not be 28e. Place of Injury - At	home, farm, stree		Yes 2 No No building, etc.	28f. Location (Stre	eet and Number	or Rural Route Number, City	
Division of Vital Division of Vital Within 24 hours after death. To the Funeral Director: After this certification in by the funeral director.	(Check only 1 Certifying Phy	vsician: To the best of my knowle niner: On the basis of examination	edge, death occur				s) and manner a	s started	
To To	29b. Signature and title of certifier				se number		29d. Date signed April 26, 200	(Month, Day, Year)	
10	30. Name and address of person v	who completed cause of death (Ite		t, Baltimore,	MD 21201				
State		2006 32. Registrar's Signa		10° 1					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Year Physician 1.15pm Edward Lemuel Brown, Jr. 2006 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner REHABILITATION BALTIMORE VERLEA HEALIH AND CENIRE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**№** M 2□ F 212-40-7410 Director Sept. 15, 1943 Maryland Usual Residence of Decedent Pagas 1 and 2 should be filiad within 72 hours aftar daath with tha Maryland nent of Haalth and Mantal Hygiana. Int: If Item 27 is marked other than "naturel", or thems 23a or 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 25s-1 show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Funeral Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 6116 Belair Road 21206 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 ÄYes 2 ☐ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 XNo Specify Specify Completed by 3 ☐ Widowed 4 ☐ Xivorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Special Education Teacher <u>Education</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Edward Lemuel Brown, Sr. (nmn) Dietrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1319 Locust Avenue, Bel Air, Maryland 21014 of Disposition (Name of Date 20c. Location - City or Town, State <u>Christine E. Eid - Daughter</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: if 4/21/06 Towson, Maryland Hilltop Service Corp. injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 50 West Broadway Street, Bel Air, Maryland 21014 Approximate Interval Between Onset and Death 23a. Pert I. Ent. r if e disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or reart failure. List only one cause in each line. Physician Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law raquires that the death certificate be executed usa as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es a consequence of) and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last page 2 should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 2010 funaral diractor. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Menner of Death Injury 5 Pending 1 Natural s aftar daath. 1 Tes 2 🗆 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide

State

To the Hospital o within 24 hours af To the Funeral Di complately filled I

fillad In

29a. Certifier

(Check only only

29b. Signature and title of certifie

EST MED Kilonan

30. Name end address of person who empleted cause of death (Item 23e) (Type, Print) KHETERPAL 201, BACKRIVER PANICAS

NECK ROAD # 109 BALTIMORE, MD 21221

29d. Date signed (Month, Day, Year)

APRIL 21, 2006

31. Date filed (Month, Day, Year) 0

32. Registrar's Signature

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29c. License number

D0660560

	For State Registrar	State of Marylar	•	ment of F <i>iicate of</i>		•	giene Reg. No.	006	13510
Physician /Medical	Decedent's Name (First, Middle, La Willonell C. Cof	•				2. Date of De Month	ath Day	Year - 2006	3. Time of Death
Examiner	,	e Hospital Sex 7. Age (In yrs.	last birthday) If	120Se Under 1 Year	Location of Dea	ath	4c. Cc	ounty of Death	place (State or Foreign
Director	219 16 9757 Usual Residence of Decedent	1□M 2⊠F 81	Yrs.	onths Days	Hours Mir	8. Date of Bir (Month, Da Jan. 5,	1925	Mary	land
deeth with the Maryland ms 23a or 28e-f show croust be notified at neral Director	Maryland Baltimo		ty, Town or Locati iddle Ri						10d. Inside City Limit 1 ☐ Yes 2√ N
Sitter deeth with the Maritems 23a or 28e-1aniher must be nutillied	10e. Street and Number			10f. Zip Code			_	n of What Cou	intry?
ms 23a	6 Manifold Ct.	12. Was Decedent Ever in U	S 13 Was	212		Specify Ven or No		JSA Race - Ameri	ican Indian
5 2 E 5	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No Il Yes, Give Year or Dates:	If Ye	yes 212 No		Specify Yes or No rto Rican, etc.)		Black, White	, etc.
15-00%	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent	of work done	during most of wi	orking	16b. Kind	of Business/li	ndustry
nd 21215-00 as tiled within 72 ho as tiled within 72 ho as Hygiene. I other than "nature went, the Medical E	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retire sembler	:			tronic	s Mfg.
re, Maryland 21215-0036 s 1 and 2 should be filled within 72 hours att the lith and Mental Hygiene. Item 27 is marked other than "natural", or other treumatic event, the Madical Experi	17. Father's Name (First, Middle, Last Clarence Crowe				Annie Lo	ume (First, Middle, Du Prophs	5		
e, Mar 1 and 2 sh Heelth and 1 m 27 is m wher treum	19a. Informant's Name/Relationship (Jack N. Coffman (Son)	6 Mani	fold Ct		Rural Route Number Nore, Mai			
Baltimore, Mar bernit. Pages 1 and 2 st Depertment of Heelth and mportant: if item 27 is n nny injury or other treun bncs.	20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	Place of Disposition cometery, cremato Lly Hill I	ry or other pla		Date 1/2006		tion - City or T Nore, N	own, State Maryland
Baltimol permit. Pages Depertment of important: if it any injury or one.	21. Signature of Funeral Service Lice	rkouske	22. Na Bru 140	ame and Addre Zdzinsk 7 Old E	ss of Facility Li Funera Lastern A	al Home E Avenue Es	P.A.	Md. 21	221
S760, cale be executed hysicien and the builal-transit dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):						Interval Between Onset and Death
al Records, P.O. Box 6. The law requires that the death certificate has been signed by the attending p. page 2 should be detached for use as Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3 □Ect	opic pregnancy ner (specify) _	,		230	l. Date of deliv Month	ery Day Year
cords, P w requires that been signed b should be deta	Part II. Other significant conditions of	contributing to death but not res	ulting in the under	tying cause giv	en in Part I.	23e. Did to	V		he cause of death?
Division of Vital Records, to attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	CHF						an 2 osy rmed? 2 No	4b. Were auto prior to co death? 1 ☐ Yes	opsy findings availab impletion of cause of
of Vital F Physician: Th this certificate ral director, pag TO Be Col	25. Was case referred to medical examiner?	Hospital:		104		ath (Check only o	ne)		
Of N Physic rathis c ral dire	1 ☐ Yes 2 Ø No 27. Manner of Death		ER/Outpatient 3	DOA Oth		Home 5 Resid			(y)
Division o To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	1 XNatural 5 Pending	9 290 Place of laive. At h	Injury		k? Yes 2 □ No				al Route Number.
Div	4 Normolae	building, etc. (Specification)	(y) 		no data and alama	City or Tox	vn, State)		
o the Hosp thin 24 hou o the Fune impletely fil	(Check only 2 Medical Exer	niner: On the basis of examina	ition and/or investi	gation, in my o	pinion, death occ	urred at the time,	date and pla	ace, and due t	o the cause(s)
T V V V V V V V V V V V V V V V V V V V	29b. Signature and title of earther 29b. Signature and title of earther 30. Name and address of person who DR Dawid Wajaria are 31. Date filed (Month, Day, Year) MAY 0 1 20	ousKi		RES		00	290. Date s	ligned (Month,	uay, Year)
H	30. Name and address of person who	completed cause of death (Iten	n 23a) (Type, Prin	t)	5		1 1.	/ 3	1737

					•			
6-02803 arry Thomas C	unn	ingham Stote	Please Type or Pri					
any momas o		1- For State	e of Maryland / Departm <i>Certific</i>	eate of Death	ınd Mentar Hy	_	2001	6 35
Physici Medical Exami	an/	Registrar 1. Decedent's Name (First, Middle,La 4d Facility Name (frot institution, gi 2233 North Pulaski Stree	Caning l	ham	or Location of Death	Reg 2. Date of Death Month E April 25, 200	ay Year	3 Time of Death 1154 hrs
Funeral Director		5. Social Security Number 6. S 212-58-00 2 1 1 Usual Residence of Decedent	Sex 7. Age (In yrs. last bir		Year If Under 24Hrs. Hours Min.	8. Date of Birth	Foreig	rthplace (State or gn buntry) ### d.
th the Maryland 23a or 28a-f show any notified at once.	Director	10a State 10b. County 10e. Street and Number	Balt	n O re		10g.	Citizen of What Cou	10d. Inside City Limit 1 Yes 2 N
r death wi or items must be	Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever in U.S.	13. Was Decedent of	2 1 6 Hispanic Origin? (Spector, Mexican, Puerto R		14. Race - Amer White, etc.	ican Indian, Black.
21215-0036 uld be filed within 72 hours afte. Mental Hygiene. marked other than "natural", e event, the Medical Examiner	Completed by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	Decedent's Usual Occup during most of working I	pation (Give kind of wo	rk done 1	6b. Kind of Business/	Industry
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than njury or other tranmatic event, the Medica	o Be Co	17. Father's Name (First, Middle, Las	ingham	b. Mailing Address (Str	18.Mother's Name (F	Car	den Surname)	
nore, MD 2121. ages 1 and 2 should be fil nt of Health and Mental I II: If item 27 is marked other traumatic event,	۲	PauleHe Curni. 20a. Method of Disposition	ngham wife 3	303 Gwy	nn Ave	Balto	20c. Location - City or	229
Baltimore, I permit Pages I and Department of Healt Important: If item		1 Burial 2 Cremation 3 4 Donation 5 Other Specification 21. Signature of Funeral Service Lice	y: Garni	Son Fors f	1A. Cem 5-4	-2004	Balto.	ud.
Balt Depart Import	_	Carlton C. &	ou factorisated the death. Do no	Carlton	Callet St.	Balb espiratory arrest	shock or heart	C. P.A. 217 Approximate Interva
/Medical xaminer		failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	each line.					Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
executed an and al - transit	al Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
O, e be exe ysician a	edic	X UNPENDED		I,27,28a-f,per	rME,g856,6/14	/06 TT		
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be evanth or: After this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time of death	Fetal death Other (Specify)	3 Ectopic pregnand	sy	23d. Date of delivery Month	y Day Year
s, P.O. puires that the signed by lid be detach	à	Part II. Other significant conditions Remote head injur	contributing to death but not resulting tess with probable seiz		e given in Part I.	1 Yes		pably 4 V Unknown
on of Vital Records, ending Physician: The law require ath pr: After this certificate has been si the funeral director, page 2 should be	Completed					24a. Was an autopsy performe	prior to death?	stopsy findings available completion of cause of the second secon
/ital sician: is certif lirector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/O	26.Pla utpatient 3 DOA	Other Nursing		sidence 6 🗸 Other	- Scena
ing Physing Physuneral d	1	1 Yes 2 No 27. Manner of Death				8d Describe how		. Scene
on endir ath or: A	tion	1 Natural 5 Pending	Fnd /1/25/2006 Fnd	11.50 cm	Yes 2 y No	mk		

Division

To the Hospital or Attent within 24 bours after death
To the Funeral Director:

3

Suicide Homicide 29a Certifier 1 (Check only one) 2 29a Certifier (Check only one) 2 Medical Exam
29b. Signature and title of certifier

31 Date filed (Month, Day, Year)

6 X Could not be determined

(Specify) Found in dwelling

28e. Place of Injury - At home, farm, street, factory, office building, etc.

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2233 N. Pulaski Street Baltimore, MD

April 26, 2006

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

ins 30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

Registrar

			- FOI	artment of Health and Mer rtificate of Death	ntal Hygien	.000 10012			
	Dhomini		1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Da	3. Time of Death			
	Physici /Medic		Jerome Joseph Dannenmann		April 28				
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Middle River		c. County of Death Baltimore			
	Francis		5 Longeron Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (Month, Day, Year				
	Funeral Director		213 34 2248	Months Days Hours Min.	(Month, Day, Year ct.24,193	7 Maryland			
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	onation		10d. Inside City Limits			
	Aaryla I ehov	٥		edale		1 ☐ Yes 2 ☑ No			
	28a-1	Director	10e. Street and Number	10f. Zip Code	10g. C	10g. Citizen of What Country?			
	h with	ai Di	8064 Roslyn Avenue	21237		USA			
	deat deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.			
36	or it	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: White			
Ö	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or items 23a or 28a-f ehow ent, the Medical Examinar must be notified at		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industry			
215	hin 72	Completed	Floreston/Secondary (0.12) College (1.4er 5.)	kind of work done during most of working DO NOT use retired)	_	W.S.			
2	ygiene ygiene er the	Соп	8 Maint	enance Mechanic		ox Mfg.			
Maryland 21215-0036	be fill	Be	17. Father's Name (First, Middle, Last) Peter Joseph Dannenmann	18. Mother's Name (F Catherine					
7	hould d Mer marks maric	ဥ		ng Address (Street and Number or Rural R					
Ma	nd 2 s lith an 27 io r treu			Roslyn Avenue Balt:	-				
ore,	of Head		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	matory or other place)		ocation - City or Town, State			
Ē	Pege ment ant: if ury or		1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify)	Crematory 5/2/200	06 Bal	timore, Maryland			
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: if Item 27 ie marked other then "natural", or Items 23a or 28a-1 show emportant: if Item 27 ie marked other then "natural", or Items 23a or 28a-1 show in Ingressing or other treumatic event, the Madical Extraction and the notified at 900s.		Michael C. Laffer St.	^{2. Name and Address of Facility} Bruzdzinski Funeral 1407 Old Fastern Ave	enue Esse	x, Maryland 21221			
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	umphia					
	Examiner		Due to (or as a consequence of):	La Accident					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- 10010-1					
	ocuted nd transli	Examiner	that initiated events	n					
8760,	icate be executed physicien and s the burial-transit	EX	Due to (or as a consequence of):	,					
687	The law requires that the death certificate be executed to hes been signed by the attending physicien and happe 2 should be detached for use as the burial-transit	Physician/Medical	d. 0/4920						
Box	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery			
	death	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year			
P.0.	res that the de signed by the a l be detached f		9 Unknown Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobacco	use contribute to the cause of death?			
ds,	signe d be c	d by	Panal Failure Volules	D G 1 SC		2 No 3 Probably 4 Unknown			
COL	w requir	letec	Comment Andrew Water	7 30 4 3	24a. Was an	24b. Were autopsy findings available			
Re	The lav	Completed	Control Hiladolecare		autopsy performed? 1 ☐ Yes 2 🗷 N	prior to completion of cause of death?			
ital	w	a l	25. Was case referred to medical	26. Place of Death (C	Check only one)				
> >	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			guter stesidence			
Division of Vital Records,	ding P. After t funera	lon:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation (2.1)	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	d. Describe how in	ury occurred			
visi	or Attending efter death. Diractor: Afte in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si		f. Location (Street a City or Town, Sta	and Number or Rural Route Number,			
۵	Hospital or A		4 ☐ Homicide Scientified building, etc. (Specify)		City of Your, Old				
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or is and manner stated.						
	withii To ti	Σ	29b. Signature and title of certified	29c. License number	29d. D	ate signed (Month, Day, Year)			
,	. ~		20 Name and address of parents who completed enurs of death (from 22a) (Tune	V-12700	7	11/06			
1	\mathcal{O}		30. Name and address of person who completed cause of death (Item 23a) (Type	Ballmarz W	11) 2	11224			
	Sta		31. Date filed (Month, Day, Year) MAY 0 1 2006 32. Registrar's Signature	and the state of t		•			
	Regist	ar	MAINTON						

	•	1 - State Registrar		artment of Health and I <i>rtificate of Death</i>	Reg.	2000	13513		
0		1. Decedent's Name (First, Middle, Last)	-		2. Date of Death Month	Day Year	3. Time of Death		
Physicia /Medic		Pietro D'Angelo			April 2	27, 2006	8:00A. M		
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deatl	n	4c. County of Death			
Funeral Director	٠	220-54-9354 1□XM 2□F	d e (In yrs. last birthday) 77 Yrs.	Catonsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 11/28/1	Baltimor ar) 9. Birth Cot 928 Mar	re oplace (State or Foreign untry) ryland		
and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits		
Maryl f sho	٥	Maryland Baltimore		Catonsville			1 ☐ Yes 2 No		
28e	Director	10e. Street and Number	1	10f. Zip Code	10g.	Citizen of What Cou	untry?		
h with	O IE	1320 Pleasant Valley Drive		21228	,	U.S.A.			
deati	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White			
72 hours after death with the Maryland naturelt, or Items 23e or 28e-f show dical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes, 2 Married 3 Widowed 4 Divorced Year or Dates:	No	1 Yes 2 No Specify:	o riidari, etc.)	Specify:	ite		
hin 72 hours an "natural" Modical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occupation hind of work done during most of wor DO NOT use retired)	rking 16t	. Kind of Business/l	ndustry		
ad with	Con	12	·	Printer		Printing			
be file fal Hy d oth	Be (17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai	r			
Meni Meni Meni Meni Meni Meni Meni Meni	မ	Antonio D'Angelo			amilla Nar				
2 sh and is m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru		-			
t and tealth sm 27 ther t		Neusa D'Angelo - Wife 20a. Method of Disposition		Pleasant Valley I		. Location - City or I	The same of the sa		
permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natu any injury or other traumatic event, it a Madical		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	Meadowri	osition (Name of matory or other place) idge Cemetery 5/2,	/2006 E	lkridge, 1	MD		
permit. Depart Import any inj		21. Signature of Funeral Service Licenses	oli 1	2. Name and Address of FacilitySte Funeral Home of 630 Edmondson Ave	rling Asht Catonsvill nue: Cator	on Schwah e,Inc. sville, M	Witzke ID 21228		
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list Immediate Cause (Final disease or condition resulting in death) a Due to (or as	ne. <i>O</i> .	ter the mode of dying, such as cardiac kemia cy ko pemio	c or respiratory arrest,	100/100/25	Approximate Interval Between Oncet and Death		
		Sequentially list conditions b.	FRN	Cy M puna					
ate be executed hysician and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events c.	a consequence of):	og w pino					
S P ica	edical	IF FEMALE: 23b. Was deceded granuari. 23c. If yes, outcome	a consequence of): a consequence of): of pregnancy 2	□Ectopic pregnancy □ Other (specify)		23d. Date of delik Month	very Day Year		
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ng Physicien: The law requires that the death certifica fler this certificate has been signed by the attending phineral director, page 2 should be detached for use as the	Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death be examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 28a. Date of Injument 28a. Date of Injument 28a. Place of Injument	a consequence of): a consequence of): of pregnancy 2	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of Dec. nt 3□ DOA Other: 4□ Nursing F. ff 28c. Injury at Work? M 1□ Yes 2□ No	24a. Was an autopsy performed 1 Yes 28ath (Check only one) lome 5 Hesidence 28d. Describe how in 28f. Location (Stree City or Town, S	Month 2 No 3 Pro 24b. Were aut prior to co death? 1 Yes 6 Other (Special prior) occurred	the cause of death? bably 4 □Unknown opsy findings available ompletion of cause of 2 □ No ify) ral Route Number,		
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			1 - For State Registrar	State of Ma	ryland	•	artment of i				giene	106	13514
		o.	Decedent's Name (First, Middle, La	st)		1				2. Date of Dea		Vees	3. Time of Death
	Physici /Medic		Edith	1) Damo	ma					aprile	工学	2006	10:00 PM
	Examir	- 0	4a Eacility Name (If not institution, giv	e street and number)			4b. City, Town,	or Location	n of Death	DINII	. 1	County of Death	
	, T E	10.25	5. Sodial Security Number 6.5	ex 7. Age	(In yrs. las	t birthdav)	If Under 1 Year	r If Unde	er 24 Hrs.	8. Date of Birt			place (State or Foreign
ï	Funeral Director			□M 2DF	97	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day 12-5-	1908	Cou	Pirot. A.
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or L	veation						10d. Inside City Limits
	the Marylar 28a-f show notified at	ō	MD N/A			1 timor							1 ☐ Yes 2 ☐ No
	28a-	Funeral Director	10e. Street and Number			TOTAL	10f. Zip Code				10g. Citiza	en of What Cou	intry?
	th with	aiD	830 W. 40th Street	Room 1123	3		21211				U.	S.A.	
	tems	nner	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of If Yes, specify Cul	Hispanic C ban, Mexic	Origin? (Spe	cify Yes or No- Rican, etc.)		1. Race - Ameri Black, White	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:	0		1□Yes 2□No	Specif	ty:			Specify: July:	ite
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-1 show he Medical Examinar must be notified at	ted	15. Decedent's E	ducation		I6a. Dece	dent's Usual Occu	pation			16b. Kind	d of Business/Ir	
218	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	kind of work done DO NOT use retire	ed)	OST OF WORKII	ng			
121	filed with Hygiene. Ither that		12 17. Father's Name (First, Middle, Last	3			Plant Wor		ther's Name	(First, Middle,		ern Elec	tric
anc	ould be fi Mental F arked of	To Be	Wilmer O. Fowler	,				18. 10101		B. Parke		arrame)	
Maryland	2 should and Men is marke	Ĕ	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Stree	at and Num				Town, State, Zi	p Code)
	and 2 salth a n 27 is	l J	Janet A. Brown- Daugh	iter			(irkwall Co	ourt To					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Middeal Examinat must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cem	etery, cre	sition (Name of matory or other pla			ate		ation - City or T	
Ë	it. Pa irtmen irtant: njury		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice)	•			emorial Par 2. Name and Addr		5/3/06			more, Mai	~yland
Ba	permi Depa Impor any ir		21. Signature of Funeral Service Licen	Heather	Cain					onard J.			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	Do not en	305 Harfor ter the mode of dy	ring, such a	as cardiac o	r respiratory ar	rest,	21214	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A .		crox	he car	dish	aser	ear a	uses	rie	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a				· · · ·					
	Examiner	-	Sequentially list conditions,	b. — Due to (or as a	consequer	nce of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events	2	, , , , , , , , , , , , , , , , , , , ,	,							
o,	ate be executed hysician and the burial-transit	Еха	resulting in death) Last	Due to (or as a	consiquer	nce of):							
8760	cate be	dicai		_ d									
89 x	death certifical attending phy of for use as th	/Med	IF FEMALE:	23c. If yes, outcome of	of pregnance	У		-			23	3d. Date of deliv	verv
Box.	death e atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic pregnand Other (specify)	су				Month	Day Year
P.0	at the by the	hys	9 Unknown	9□ Unknown									
	faw requires that the death certifics as been signed by the attending pt 2 should be detached for use as t	by	Part II. Other significant conditions of Multiple Yu				-		rt I.		obacco us 'es 2 🗷	/	the cause of death? bably 4 □Unknown
Records,	w require been si should I	Completed		geana	<i>J</i> -00	10 000	1411040						
Rec	The fav	mpi								24a. Was autop perfor	rmed?	prior to co	opsy findings available empletion of cause of
Vital	an: TI tificate tor, pa	a)	25. Was case referred to medical	-				26. Pla	ace of Derath	1 Yes	2 1 No	1 🗌 Yes	2 □ No
ίV	Physician: this certificatal director, p	ToB	examiner? 1 Tyes 2 Mo	Hospital: 1 Inpatier	nt 2 EF	VOutpatie	nt 3 DOA	ther	/	ne 5 ☐ Resid		□Other (Speci	fy)
n of		on:	27. Mann 1 Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time o	W			28d. Describe h	now injury	occurred	
Division	Attending r death. ector: After y the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e One Place of Inju	ry - At home	a farm et		Yes 2		28f Location /S	Street and	Number or Bur	al Route Number,
Ď	al or A after I Direct	Certification;	4 Homicide determined	building, etc	. (Specify)	, rairi, oc	oot, radory, onloc			City or Tow			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying PI (Check only one)	nysician: To the best of miner: On the basis of and manner state	examination	edge, deat n and/or in	h occurred at the t vestigation, in my	time, date opinion, de	and place, a	and due to the ded at the time, d	cause(s) a date and p	nd manner as s place, and due t	stated. to the cause(s)
	To the within To the compli	Me	29b. Signature and title of certifier	1 ^	, .			se numbe			W 4	signed (Month,	- /
	0		In Trabelee 1	as frege	r m		D13	3657	7	7	May	1,20	06
	4		30. Name and address of person who 7 IS AB ELLE TO	completed cause of de	eath (Item 23	3a) (Type,	Print) 404 Si	REE	T) B/				
	Sta		31. Date filed (Month, Day, Year)	32 degistra									
	Regist	ar	MAY 0 1 2	006	a selfs	1	342						

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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		•	For State Registrar	State of Man		partment of H e <i>rtificate of l</i>			giene Reg. No.	06	13515
	4 (4)		1. Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic			Ardella	Doris El			April	24	2000	
	Examin	er	4a. Facility Name (If not institution, give			Baltin	Location of Death		4c. Co	unty of Deat	h
\$ 1 20	Francis	9	Sinai Hospital of 5. Social Security Number 6. Se		In yrs. last birthda) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h .	9. Birtl	hplace (State or Foreign
, vi	Funeral Director			□м 2КX F 6	8 Yrs.	Months Days	Hours Min.	(Month, Da 7-24	y, Year) -1937	Co	N.C.
	pu s		Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town or	Location					10d. Inside City Limits
	Aaryla F shor	٥	,	lto		Mills					1 ☐ Yes ¾(∑ No
	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Co	untry?
	th with	aiD	7905 Valley Man	or Road Uni	t D	21	117		U	S A	
	r deal	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	B. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Ame Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than Mazical Examinar must be notified at	by Fi	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Sp	ecify: B1a	ick
5-0036	2 hou	ted	15. Decedent's Edu	ication	16a. Dec	edeni's Usual Occup	ation		16b. Kind	of Business/	Industry
21215	thin 7.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life	ve kind of work done of DO NOT use retired	during most of work ()	ing	Clif	ton T.	Perkins
2	led wi		12th grade	2 years	3 I	P N Nurs	e 18. Mother's Nam	o /First Adidado	Maridae Cu	mama l	
Maryland	ntai H ed ot	Be	17. Father's Name (First, Middle, Last) Ardell Ellibe				Bertha P		Malden Su	mame)	
2	should nd Me mark mark	ြ	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Ma	iling Address (Street			er, City or To	own, State, Z	Zip Code)
	alth author 27 is		Brenda Templin -	Sister	56	43 Open S	ky Colum	bia. Md	2104	4	
altimore,	of Hear fitem		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ I		20b. Place of Dis	position (Name of rematory or other place		Date		ion - City or	Town, Slate
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify,		Md Nati	onal Memo	rial 5-1-			el, Md	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinar must be notified at one.		21. Signature of Funeral Service Licens	elmone		22. Name and Addres 4300	ss of Facility Wabash	March Avenue		est o, MD	21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused thene cause on each line.	e death. Do not e	inter the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Se	PSis						Onset and Death
ì	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):						3
	A. #	9r	Sequentially list conditions,	b. Due to (or as a c	01.07.	lure					Syears
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,						
ó	exect en and rial-tra	Exa	resulting in death) Last	Due to (or as a c	consequence of):						
68760,	icate be executed physicien and s the burial-transit	edicai		d.							
_		/Med	IF FEMALE:	23c. If yes, outcome of	programmy						
P.O. Box	The law requires that the death certif te has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months?	23c. If yes, outcome of 1□Live birth 2 (4□Pregnant at tin	Fetal death	B Ectopic pregnancy			23d	I. Date of deli Month	ivery Day Year
o.	the de	ysic	1 ☐ Yes 2 Ø,No 9 ☐ Unknown	9□ Unknown	no or douth	- Cirioi (apeciny)					
	s that ned b	by Pi	Part II. Other significant conditions co	ntributing to death bul	not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use	coniribute lo	the cause of death?
rds	w require been sig should b		Drubetes Mellitus					10,	Yes 2□N	No 3□Pr	obably 4 Dunknown
Division of Vital Records,	law re as be 2 sho	Completed						24a. Was	osy	24b. Were au	stopsy findings available completion of cause of
<u>~</u>		Соп						1 Yes	rmed? 2 X No	death?	2 💢 No
Vita	icien: certific ector.	Be	25. Was case referred to medical examiner?	Hospital:		ont 30 DOA Oth	26. Place of Deat				
ō	Phys	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 2 Inpatient 28a. Date of Injury	2 ER/Outpat	IGHT 3 DOX	4 Nursing no	ome 5 ☐ Resident			cify)
O	or Attending Physicien: ufer death. Director: After this certifics in by the funeral director, I	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear) Injury	Wor	k? Yes 2 □ No		.,,-,,	1000	
Visi	Atter	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury building, elc.		street, factory, office		28f. Location (. City or To		lumber or Au	ural Route Number,
ō	rs after or salt or sa	Certification:	T I Normoled	Banang, orc.	(орвену)			Only 01 70	www. Otaloy		
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edicai		rsician: To the best of iner: On the basis of each manner state	xamination and/or						
	within To th	Me	29b. Signature and title of certifier			29c. Licens			29d. Date s	igned (Monti	h, Day, Year)
	1		Ocean way	4 DO		Res	,-000		April	124,	2006
	10		30. Name and address of person who	completed cause of dea	th (Item 23a) (Typ		of Balti	2017-2			
66	Sta	į atę	31. Date filed (Month, Day, Year)	32. Posistrar's	s Signature	TWITTE .	W- 06111	11166			
	Regist		MAY 0 1 2	2006	JK A	goods.					

		4	For State Registrar	State of Marylar		rtment of H tificate of I		ntal Hygie	ZUUD	13516
	Physicia	an	Decedent's Name (First, Middle, Last)	. (11-			2	. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Melvin Wa		5	4h Cib. Town or	r Location of Death	April	29, 2006 4c. County of Death	13:28 M
	Examin	er	4a. Facility Name (If not institution, give s	A .		111	muste/		Carro	./1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8	Date of Birth	9 Right	place (State or Foreign
	Director			M 2□F 78	Yrs.	MOIIIIS Days	Hours Will.	Month, Day, Y une 27,	1927 Mary	Tand
	and wo		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loc	cation			1	0d. Inside City Limits
	Mary B-f sh	tor	Md. Carroll	- Paris de la company de la co	Manches	ster				MYes 2□No
	or 28	Director	10e. Street and Number 3380 Main St.			10f. Zip Code	2		. Citizen of What Cou	ntry?
	s 23a	rall			10 10 11	2110			U.S.A.	- 1 - F
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show appringuty or other traumatic avent, The Madical Examinating the inclined at ances.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☑Yes 2 ☑ No If Yes, Give Year or Dates:	lf lf	Yas Decedent of H Yes, specify Cuba	ispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	ty Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	ent's Usual Occup	ation during most of working	16	b. Kind of Business/In	dustry
121	within ane. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use retired	i) "		. S. Posta	1 Samurian
	filed Hygie other		17. Father's Name (First, Middle, Last)		0.000		18. Mother's Name (r pervice
<u>lan</u>	Ald be Aental rked c	To Be	Clyde Ellis				Lena			
Maryland	and N	. 3	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or Rural F	Route Number, C	City or Town, State, Zip	Code)
	l end fealth im 27 her tr		Karen Ganjon - Da				Shop Rd.		ster, Md.	
Baltimore,	Pages then of the tant: If Ite		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	w Luthe		May 3, 20		anchester,	•
Bal	permit Depar Impor any in		21. Signature of Fyrancervice License	ladt	22. Ec	. Name and Addres ckhardt F	ss of Facility uneral Cha	pel, P.		rmil Dr., er. Md21102
			23a. Part1. Enter the disease, or complice shock, or heart failure. List onty on	cations that caused the dear e cause on each line.	th. Do not ente	er the mode of dyin	g, such as cardiac or r	espiratory arrest		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Me Fas F	afiz	Colone	Eancer	-	x	Onset and Death
п	Examiner		Sequentially list conditions, b							
Т	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence oi).					
Ć,	icate be executed physicien and the burial-transit	Examiner	that initiated events c resulting in death) Last	. Due to (or as a consec	quence of):					
38760,	ate be nysicie he bur	dical	d							
•	ertifica ling ph e as t		IF FEMALE:			- m	1 11-1-1-1			
.O. Box	that the death certifined by the attending I	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	ery Day Year
<u>a</u>	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the un	derlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Ş	w require been sig should b							1 🗆 Yes	2 Prob	pably 4 □Unknown
I Records,	The ate h page	Completed		-				24a. Was an autopsy performe	prior to co	ppsy findings available impletion of cause of 2 No
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death (Check only one)		
o	Phys rthis raldii	- To	1 Yes 2 No	28a. Date of Injury	28b. Time of		4 Nursing Home	5 Residence d. Describe how	be 6 Other (Special	(y)
on	nding Fith. :: After is funera	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗍	k? Yes 2 □ No		injury dodginod	
Division	if or Attend after death Diractor: /	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office	28	f. Location (Stree City or Town,	et and Number or Rura State)	al Route Number,
۵	Hospital or Attending 4 hours after death. Funaral Diractor: After fely filled in by the fune									
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	edical	(Check only 2 Medical Examir	ician: To the best of my knier: On the basis of examination and manner stated.	ation and/or inv	estigation in my o	ninion, death occurred	at the time, date	and place, and due to	the cause(s)
	To the Comp	ž	29b. Signature and title of certifier			29c. Licens	e number	29d	. Date signed (Month,	Day, Year)
•	5	9.	· with yh	ans		Doc	58137		4/29/20	06
	0	109	30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, I	Print) = 307	Wester	ns for	MD 211	57
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 1 2006	and manner stated. M D mpleted cause of death (Item S Foner 3. Registrar's Sign	ature Ann	de)	-71-541	- 101		
			WHI O T 5000	REGISED PO	1 all and					

State Registrar

5

M. EUTAW

32. Registrar's Signatur

ST Smile 308, BALTIMOREMPZIZV

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

SHMI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

			1 - For State Registrar	State of Maryland / D	Department of H Certificate of L		ntal Hygien Reg. N	En UUU	13519					
	Physici		1. Decedent's Name (First, Middle, Last) Burnie Forbes,				Date of Death Month	2006	3. Time of Death 9:45 p M					
ز	/Medic Examir		4a. Facility Name (If not institution, give s Carroll Hospital C	enter	4b. City, Town, or Westmins	Location of Death	4	c. County of Death						
B	Funeral Director		5. Social Security Number 6. Sex 246–12–2990 15	7. Age (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day Yea	9. Birth	place (State or Foreign					
	Maryland a-f chow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	10c. City, Town	or Location				l Od. Inside City Limits					
	with the	i Direc	10e. Street and Number 5211 Hoffmanville	Rd.	10f. Zip Code	102	10g. C	U.S.A.	ntry?					
36	irs after deeth il', or Items 2: Xaminer mus	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates;	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify In, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Americ Black, White,						
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mental Hygiene. Depertment of Heath and Mental Hygiene. Bright of Heath and Mental Hygiene. Bright of other traumatic event, the Mouleal Examinar must be notified at an songe.	Be Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. completed) College (1-4or 5+)	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired arpenter	ation during most of working 1)		Kind of Business/In	dustry					
Maryland 2	uld be filed Vental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) John Forbes		Ja	18. Mother's Name (Fi	rst, Middle, Maide							
Mary	nd 2 sho alth and 1 27 is ma ir trauma		19a. Informant's Name/Relationship (Ty. Dixie Cristofaro –		Mailing Address (Street a				Code)					
Baltimore,	Pages 1 a ent of Hes nt: if Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemeter	Disposition (Name of y, crematory or other place	Date	20c.	Location - City or To						
Balti	permit. Depertm Importate any inju		21. Signature of Funeral Service License											
	Physician // Medical but site of the private of the	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	S 15	y, such as caldiac of re	spiratory arrest,		Approximate Interval Between Onset and Death					
	law requires that the death certificate as been signed by the ettending phys 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive	ery Day Year					
rds, r	quires thet n signed b uld be deta	þ	Part II. Other significant conditions con	atributing to death but not resulting in	the underlying cause give	en in Part I.		ouse contribute to to						
Ť	The ate h page	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available mpletion of cause of					
of Vital	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner?	lospital: 1 Dinpatient 2 ER/Ou	tpatient 3 DOA Othe	26. Place of Death (C		6 Clother (Consti						
ion of	To the Hospital or Attending Phys within 24 hours eiter death. To the Funeral Director: Affer this completely filled in by the funeral directors.	ation: T	27. Manner of Death 1 Thatural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. 1	ime of 28c. Injury		Describe how in		у)					
Division	Ital or Att its efter de ral Directo led in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)			City or Town, Sta							
	the Hospi in 24 hou the Funer pletely fill	Medical	(Check only 2 Medical Examinations)	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	, death occurred at the tin d/or investigation, in my o	ne, date and place, and pinion, death occurred a	due to the cause at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)					
	To T Com	Σ	29b. Signature and title of cardiller	Mes MD	29c. Licens	o number 00 54 2	18 0	Date signed (Month, 4-28	Day, Year) -06					
5	1		30. Name and address of person who co	mpleted cause of death (Item 23a) (KAN 2US 347 IV	Type, Print) Nolcalm du	re, Wen	munta	MD 211	57					
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sparke		•							

DHMH 17 Rev 1/2001

Registrar

MAY 0 1 2006

	1	Amend item#4b-c,p	State 895Matylaho	Љера <i>Cer</i>	irtment <i>tificate</i>	of He	ealth and leath	Men	tal Hygie	6. 0 1	16	13520
Physici	an	1. Decedent's Name (First, Middle, Last) Catherine C.	Funk		-				Date of Death Month 11 29	, ^{Day} 2006	Year	3. Time of Death
/Medic Examin	er	4a. Facility Neme (If not institution, give str 422 E1mwood Road			-Bal	timor		rlea		4c. Count	Ba]	ltimore Count
Funeral Director		213-10-0732	7. Age (In yrs. la	st birthday) Yrs.	If Under Months	Days	If Under 24 Hr. Hours Mir	De	Month Day, y	922	Mary	place (State or Foreigr ntry) ' Land
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County N/A	10c. City,	Town or Lo							10d. Inside City Limits 1 □Yes 2 □ No	
with the	I Direc	10e. Street and Number 422 Elmwood Road			10f. Zip	^{Code} 1206			100	. Citizen of U.S		ntry?
after death or ftems 23	Funera		. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 W No If Yes, Give X Year or Dates:	l.	Was Deced f Yes, spec	rify Cuban	panic Origin? (, Mexican, Pue Specify:	Specify into Rica	Yes or No- in, etc.)		ack, White,	can Indian, , etc. White
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinal Livial be notified.	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa (Specify only highest grade of the control of th	16a. Deced	^					b. Kind of E			
iled within tygiene. ther then '	Comp	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		memak	er	18. Mother's N	ame (Fi	rst, Middle, Ma	Own		
should be find Mental H marked of umatic ever	To Be	William Valentine 19a. Informant's Name/Relationship (Type)		10h Mailin	og Address	(Street a	Cather		Kunigu		Noha	ip Code)
1 and 2 sh Health and Im 27 Is n ther traum		Mr. Gilbert R. Funk	, SrHusband	422	Elmwo	od R	oad Bal		ore, Ma	rylan	d 212	
permit. Pages Department of h Important: if its any injury or or once.		1 Webside of Superior 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Par	kwood	Ceme	tery		/06	nard J			Maryland
Depar Impor		> Hearle	, Caeri	5	305 H	arfo	rd Road	Bal	ltimore	, Mar	•	
Physician /Medical Examiner prize percented the prize transit the prize transit transi	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										Onset and Death
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be deteched for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	⊒Ectopic p ⊒ Other (sp						ate of deli	very Day Year
uires that I signed by Id be dete	Ď	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the u	underlying (cause give	en in Part I.			cco use co 2 □ No		the cause of death?
The law requirate has been so	Completed							-	24a. Was an autopsy perform		prior to death?	topsy findings availal completion of cause of 2 \square No
cian: ertific ector,	Be	25. Was case referred to medical examiner?	ospital:		nt 3□ D	Othe	.		heck only one			<u> </u>
27. Manner of Death 28a. Date of Injury 28b. Time of Injury							at (? Yes 2 □ No		5 Resider 1. Describe hor			ory)
i or Attendi after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	treel, factor	y, office		281	Location (Str City or Town,	eet and Nur State)	mber or Ru	iral Route Number,		
To the Hospitei or Attent within 24 hours after death To the Funerei Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred nvestigation	I at the tin	ne, date and pla pinion, death o	ace, and	due to the ca at the time, da	use(s) and te and place	manner as e, and due	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	~-			D_{5}	9 number 4 8 4	11	29	d. Date sign	12	h. Day, Year)
19		30. Name and address of person who co	mpleted cause of death (Item	1 23а) (Туре	, Print)							
S Regis	tate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	iture	and I							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Death Month	Day Year	3. Time of Death 2145 hrs
dical Exami	ner	Larry 4a. Facility Name (if not institution, give stre	Tyrone	Gre L4b City 1	ene Jr. own, or Location of Deal	April 20, 20	4c. County of D	
		University Hospital-Shock Tra		Baltin			,	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under	er 1 Year If Under 24Hr	_		. Birthplace (State or preign
Director		213-86-9951	2 F 32	Yrs.	S Days Hours Wil	07 2		Country) MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
ind show :	_	MD NA	Bal	timore				1 XYes 2 No
Maryla 28a-f d at or	Director	10e. Street and Number		10f. Zip		10	g. Citizen of What (Jountry?
ith the Maryland 23a or 28a-f show any notified at once.		1610 Cliftview			21213		U.S.	
ath wi	Funeral	11. Marital Status 12. 1 X Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?		nt of Hispanic Origin? (& y Cuban, Mexican, Puert		14. Race - Al White, et	merican Indian, Black, c.
offer de	by Fu	3 Widowed 4 Divorced If Ye	Yes 2 X No es, Give Year Dates:	1 Yes 2	No specify:		Specify:	Black
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	ed b	15. Decedent's Education (Specify only hi	ghest grade completed) 16		Occupation (Give kind of king life. DO NOT use re		16b. Kind of Busine	ess/Industry
36 nin 72 e than "	Completed	Elementary/Secondary (0-12) 11th grade	College (1-4 or 5+)	Pool B	uilder		Sterling	g Pool Co.
215-0036 be filed within 7 ttal Hygiene thed other than ent, the Medica	Con	17. Father's Name (First, Middle, Last)	114	1001 2		ne (First, Middle, M		, 1001 001
21215-0036 uld be filed within 72 hou Mental Hygiene marked other than "nat c event, the Medical Exa	Be	Larry Greene Sr.	Dist	40h Mallian Addans	Barbara	a Dance		
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	P	19a. Informant's Name/Relationship (Type, Constance Greene	-Sister	1200 Nor	Barbara (Street and Number or th Longwood	od Stre	et. Bali	to, Md ²¹⁶
		20a. Method of Disposition	20b. Pla	ice of Disposition (Nar	ne of cemetery,	Date	20c. Location - City	
Baltimore, permit. Pages I a Department of He Important: If ite injury or other to	Ų	1 X Burial 2 Cremation 3 F	Cernoval Ironi State	t. Carme		28/06	Baltimo	ore, Md
Baltimo permit. Page Department Important: injury or oth		21. Signature of Funeral Service Ligensee	1/	22. Name and	Address of Facility F/H West		-	-
Physician		23a. art I. Ent. the disease, or complicati	ons the caused the death. Do	14300	Wabash Ave	e, Balt	imore, I	Md 21215 Approximate Interval
/Medical		tilure. List inly one cause on each lin				,		Between Onset and Death
Examiner			to (or as a consequence of):					-
	-	Sequentially list conditions, bb	to (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
uted d ansit		events resulting in death) Last Due d.	to (or as a consequence of):					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	edical	UNPENDED	MENDED			.		
68760, certificate be nding physic se as the bur	Σ	IF FEMALE: 23b. Was decedent pregnant in the 1	3c. If yes, outcome of pregnar		2		23d. Date of deli	,
x 68 th certi	cial	past 12 months?	Live birth Pregnant at time of death	2 Fetal death 5 Other (Spe	3 Ectopic pregration Sify)	laricy	Month	Day Year
cian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as	Physi	Part II. Other significant conditions con		Uting in the underlying	seuse sives is Best I	220 Did tok	Dogge upp goptribut	a to the saves of death?
P.O	þ	Part II. Other significant conditions con	tributing to death but not resu	uiting in the underlying	cause given in Part I.			e to the cause of death? Probably 4 Unknown
ds, require	Completed					24a Was a		e autopsy findings available
ecor ne law te has l	Jdmo					autops perform 1 ✓ Yes 2	ned? deat	
	ധ	25. Was case referred to medical			26.Place of Death (Check	(=_J		Yes 2 No
of Vital Records, ing Physician: The law require After this certificate has been simmeral director, page 2 should be	To B	examiner? 1 Yes 2 No	Impatient 2 V Er					ther:
n of ding Pl h : After e funera	on:	27. Manner of Death 1 Natural 5 Pending	(Month Day Year)	8b. Time of Injury 2 2121 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	Subject shot	ow injury occurred	
Division tal or Attendii rs after death al Director: Aled in by the fu	ficat	2 Accident Investigation	28e. Place of Injury - At home	e, farm, street, factory		28f. Location (St	reet and Number or	r Rural Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifiely filled in by the funeral director,	Certificati	3 Suicide 6 Could not be determined	(Specify) Outside of ac	ddress		or Town, Sta	ate)	Street, Baltimore, M
To the Hos within 24 hd To the Fun		(Silver Silv)	To the best of my knowledge,					
To the within 2 To the complet	Medical	2 🗸	the basis of examination and/ manner stated.		: License number	at the time, date a	29d Date signed	
	===	1/1/1/)(· ·		O.C.M.E.		April 21, 2006	
		3 Name and address of person who comp	pleted cause of yeath (IV m 23	3a)				
2		# ** * * **	ant Medical Examiner		et, Baltimore, MD	21201		
S Regis	tate trar	###\$\/ A -4 0000	32. Registrar's Signature	Special .				
- regis	التفد	1111 0 T 5000	The second secon	4				

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		•	For State Registrar	,		tificate of			Reg. No.	6 3522
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of De. Month		3. Time of Death Year
	/Medic	ai .	ETTA				VITZKY	APRIL	26 200	
-6	Examin	er	4a. Facility Name (If not institution, give str 5346 WENDY ROAD	eet and number)		4b. City, Town, o		Jeath	4c. County o	ROLL
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. ia	st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bird		Birthplace (State or Foreign Country)
ige.	Director		210-01-7307	^{4 2} X ^F 86	Yrs.	Months Days	Hours	Hrs. 8. Date of Bin (Month, Da 07/20/	1919	MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation		1.0.700		10d. Inside City Limits
	Mary a-f eh	tor	MD CARROLL	S	YKESV	ILLE				1 ☐ Yes 2 🛣 No
	within 72 hours after death with the Maryland ene. than "neturel", or iteme 23a or 28a-f ehow the Modical Exameter must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
	e 23a	rail	5346 WENDY ROAD	. Was Decedent Ever in U.S	10	217		2 (Coast Vess Ale	U.S	A.
	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?				n? (Sp <i>eci</i> fy Yes or No Puerto Rican, etc.)	Bfack	k, White, etc.
21215-0036	rel', o	þ	3 Widowed 4 □ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes aX No	Specify:		Specify:	. WHITE
5-0	"natu	Completed	15. Decedent's Educa (Specify only highest grade of		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most o	f working	16b. Kind of Bus	siness/Industry
12	withir iene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		RIETOR	<i>a)</i>		SAMMY'S	DEPT. STORE
	be filed ital Hygid od other event, II	Be C	17. Father's Name (First, Middle, Last)		131			s Name (First, Middle,		θ)
ylaı	should band Ments or marked	To	LOUIS			DLER	CELIA			HAMBURG
Maryland	d2 ha 7 to		19a. Informant's Name/Relationship (Type SHIRLEY CRISTOFARO					or Rural Route Numbe KESVILLE,	•	
	f Heali item 2 other	1	20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other pla		Date		City or Town, State
<u>E</u>	Pages nent of ant: if it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei 4 ② Donation 5 ☐ Other (Speciff)	moval from State BETH				1/28/2006	RANDALL	STOWN, MD
Baltimore,	permit. Departe Importe any inj		21. Juny ure of Funeral Privice Lice see	_		2. Name and Addre		SOL LEVIN		
170	40384		23a Part Enter the disease of complete	gons that caused the death	Do not ent	900 REIS	TERSTON	NN ROAD -	PIKESVIL	LE, MD 21208 Approximate
	Physician		23a. Pan 1. Enter the disease, of complete shock, or heart failure. List only the Immediate Cause (Final	cause on each line.	ובוו	INKO	0/-		,	Interval Between Opset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequent	ence of):	INTR	1-111	κ		VIF3
·	Examiner	S.,	Sequentially fist conditions, b.	RAGUS)					Prs.
	ned nsit	Examiner	Sequentiafly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence or):					
ó	te be executed ysician and e burial-transit		that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
8760,		lical	d.							
x 68	certific iding p	/Med	IF FEMALE:	c. If yes, outcome of pregnan	cv				22d Date	e of delivery
Вох	death certifica e attending ph ed for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of de	death 3	Ectopic pregnanc Other (specify) _	у		Mon Mon	
P.0.	at the	hys	9 Unknown	9□ Unknown						
	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contr	ibuting to death but not resul	ting in the u	nderlying cause gr	ven in Part I.	23e. Did t	1	ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
COL	he law require s has been sig ge 2 should b	ietec		1,311	117	10/0		24a. Was		Vere autopsy findings available
Vital Records,	The la ate has page 2	Completed						autor	osy pr	rior to completion of cause of leath?
ital		BeC	25. Was case referred to medical examiner?					f Death (Check only o	- V	
	d is	၉	1 ☐ Yes 2 ☑ No Ho 27. Magher of Death		P/Outpatier	IL 3L DOA		ing Home 5 Resident	dence 6 Othe	
on	Attending ir death. ector: After by the fune	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No		iow injury occurre	, ,
Division of	r Attend er death rector: / by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		reet, factory, office		28f. Location (: City or Tox		er or Rural Route Number,
ā	oital or urs afte eral Dir illed in									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my know er: On the basis of examinati and manner stated.	on and/or in	n occurred at the ti vestigation, in my	me, date and popinion, death	occurred at the time,	cause(s) and man date and place, a	and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	No 8	7	29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	4		Nay Deple	- Irlupt	マ	1	080C	29	4-6	6-06
1	0		30. Name and address of person who com	S . MD				•		
8	Sta		31. Date lifed (Month, Day, Year)	32. Régistrar's Signatu	The A	me				
100 m	Registr	ar	MAY 0 1 20	106						

	an	Decedent's Name (First, Middle, La	st) Ch	arlotta	Green	2. Date of Month	Day Year	1 . 0
Леdіс amir		4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, or	Location of Death	4c. County of Dea	
	101	Worthmast	Krinits1	1	Royda	unt our	1312:	
al		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthda	Months Days	Hours Min. 8. Date of (Month,		irthplace (State or Forei country)
		214-22-1669 Usual Residence of Decedent	X	80 Yrs.		03/03/	1926	MD
		10a. State 10b. County		10c. City, Town or I	Location			10d. Inside City Limi
1	ğ	MD BALTIN	10RF	RΔI	TIMORE			1 ☐ Yes 2 ☐ N
	i e	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	Country?
	alc	6529 COPPERFIELD	ROAD		2120	9	U.	S.A.
hv Filbo	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Specify Yes or in, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Am Black, Wh Specify:	
	eted	15. Decedent's E (Specify only highest gra		16a. Dec	edent's Usual Occup	ation during most of working	16b. Kind of Business	s/Industry
	ğ	Elementary/Secondary (0-12)	College (1-4or 5+) life.	DO NOT use retired	i)		
		17. Father's Name (First, Middle, Last,		OWNE	R	18. Mother's Name (First, Mid	JEWEL1	RY
) Be	HYMAN	,	KA	HN	EDITH		LDBERG
ľ	၉	19a. Informant's Name/Relationship (Type, Print)		!	and Number or Rural Route Nu		
		HOWARD GREEN / S					ALTIMORE, MD	
		20a. Method of Disposition	Domoughter Co.	20b. Place of Disp cemetery, cr	position (Name of ematory or other place	Date	20c. Location - City of	
١		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif		ARLINGTO	IN CHT7IIK	04/27/200	6 BALTIMORE	, MD
		21. Signature of Fundral Service Licer	1900	Alleno Go	22. Name and Addres	ss of Facility SOL LEVI	NSON & BROS.	TNC
-	-	and	0.		8900 REIST	ERSTOWN ROAD -	PIKESVILLE	MD 21208
		23a. Part 1. Enter the disease of com shock, or heart failure list only	plications that caused to one cause on each line	he death. Do not e	nter the mode of dyin	g, such as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
		Immediate Cayse (Final disease or condition resulting in death)	a. Aspira	Tion PI	remayil &			Onset and Death
			Due 🏚 (or as a	consequence of):				
	ē	Sequentially list conditions,	b. Due to (or as a	process and the same of the sa				
		Il any, leading to illimediate		consequence of).				
ľ	Ē	it any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence or).				
	Examir	day, leading to infinediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				
	Ca	that initiated events	c					
	ysician/Medical Examiner	that initiated events	c	consequence of):	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	blivery Day Year
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			1 - For State Registrar	ate of Ma		artment of Health and rtificate of Death	Mental Hyg		13524
	Dharini		Decedent's Name (First, Middle, Last)		-		2. Date of Deat Month	th Day Year	3. Time of Death
	Physici /Medio		DORC	THY EL	IZABETH	HEFFNER	APRIL	27, 2006	10:30 A ^M
	Examir	er	4a. Facility Name (If not institution, give stree		-	4b. City, Town, or Location of Dea		4c. County of Death	
			CARROLL LUTHERAN			WESTMINSTE		CARROLI	
	Funeral		5. Social Security Number 6. Sex 1 M		(In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir	. (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent		_90		9/16/19	915MAR	YLAND
	/land		10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
	the Marylar 28a-f show	ţŏ	MD CARROLL		WESTM:	INSTER			1 ☐ Yes 2X No
	or 28g	irec	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What Cou	intry?
	23a c	Funeral Director	73 LIBERTY ST.			21157		USA	
	itams	ner	11. Marital Status	Vas Decedent E	ver in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ameri Black, White	
98	or It	F	1 Never Married 2 Married	☐ Yes 2 No f Yes, Give	o	1 ☐ Yes 2 🏋 No Specify:	.,,		
5-0036	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show selecal Examiliation that be inclifted at	d by	3½ Widowed 4 □ Divorced	ear or Dates:				77	HITE
5	c * 3	Completed	15. Decedent's Education (Specify only highest grade control of the control of th	n npleted)	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	16b. Kind of Business/Ir	ndustry
2121	within ene. than "	ш	Elementary/Secondary (0-12)	College (1-4or 54	-)	CAFETERIA WORK	ER S	SCHOOL	
	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle, A	Maiden Surname)	
Maryland	s 1 and 2 should be filed withir f Health and Mental Hygiene. Itam 27 is marked othar than other traumatic evant, Itte Ma	To B	GEOR	GE EZRA	A DINTER	MAN LETT	IE ODA S	STRAWSBUR	G
ary	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Туре,	Print)	19b. Maili	ng Address (Street and Number or F	Rural Route Number,	City or Town, State, Zi	p Code)
	alth ar 27 is r trau		DARLENE E. WEEKS	-DAUGH	TER 107	COURIER Ct. Ta	aneytown	, MD 2178	7
Baltimore,	ges 1 and 2 it of Health if Itam 27 i	-	20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place)	Date	20c. Location - City or T	own, State
Ĕ			1 XBurial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)		1	RANCH CEM. 5/4	/06 V	WESTMINST	ER. MD
a E	permit. Page Department Important: If any injury o		21. Signature of Juneral Service Licensee			2. Name and Address of Facility F	and the second second		
m	Dep Dep any				2.	54 E. MAIN ST.	, WESTMI	INSTER, M	21157
	Physician /Medical Examiner	10	23a. Part1. F (ser the disease, or complication shock, of art failure. List only one commendate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	Due to (or as a	consequence of):	er the mode of dying, such as cardid	ac or respiratory arre	est,	Approximate Interval Between Onset and Ceath
€8760, €	ificate be executed g physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Adv	consequence of):	Demuter			3505
P.O. Box	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Med	in the past 12 months?	f yes, outcome of Live birth 2 I Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
	es tha gned be del	by P	Part II. Other significant conditions contribu	iting to death but	t not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to t	
ord	equir sen si ould	ted	Chronic (b) hec	PAT			1 🗆 Ye	s 2. No 3 □ Proi	bably 4 Unknown
al Records,		Completed		<u> </u>			24a. Was ar autops perform 1 Yes 2	v prior to co	opsy findings available impletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	tal:		0.1	eath (Check only one		
of	Phys this ral di	- 10	1 195 2 10	1 Unpatien	1000	1 3 DOA 4 Nursing	Home 5 Reside 28d. Describe ho	nce 6 Other (Specia	fy)
on	ding After fune	tlon	The contract of the contract o	Ba. Date of Injury (Month, Day	Year) Injury	8c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe no	w injury occurred	
isi	r Attanding er death. ractor: After by the funer	lcat	3 Suicide 6 Could not be	Re Place of Injur	y - At home, farm, str		28f. Location (Str	reet and Number or Run	al Route Number
Division	after Dirac	Certification:	4 Homicide determined	building, etc.	(Specify)	1	City or Town	, State)	ai rioute ivaniber,
	To the Hospital or Attanowithin 24 hours after death To tha Funaral Diractor: completely filled in by the	edical	(Check only 2 Medical Examiner:	n: To the best of On the basis of and manner state	examination and or in	n occurred at the time, date and place vestigation, in my opinion, death occ	ee, and due to the ca curred at the time, da	ause(s) and manner as sate and place, and due t	stated. o the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	//	//	29c. License number		9d. Date signed (Month,	
			1	1	1	137949	1	Sovel 27	th 2000
	Sta Registr		30. Name and address of person who complete the state of person who complete the state of the st	32. Registral	Kyn Qu	Print)	rendus	Sprol 27	aus7
			₩AV 0 1 2006	1 60 A ST . S. S.	2 10				

ORIGINAL

	-	For State of Maryland / Department of Health a State Certificate of Death			G. U	06	135	25
		Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)		Date of Deat	eg. No.		3. Time of	Death
Physician /Medical		Jerome P. Haulsworth, Jr.		RIL	25°,	2006		Рм
Examiner		4a. Fecility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER 4b. City, Town, or Location of TOWSON	of Death			ty of Death		
			24 Hrs a	Date of Birth	BALTI		nines (Casta a	- Famire
Funeral Director		215-50-8288 1MM 2 F 56 Yrs. Months Days Hours		(Month, Day)	9 4 9	9. Birth Cou	place (State of MD	Foreign
and *	1	Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10c. City, Town or Location					10d. Inside Cit	y Limits
Manyl	5	MD Baltimore White Marsh					1 🗌 Yes	2½ No
the 128	3	10e. Street and Number 10f. Zip Code		1	0g. Citizen o	f What Cou	intry?	
N with h with h with h	2	11724 Philadelphia Rd. 21162			USA			
deat deat		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Ori	rigin? (Specifi	y Yes or No-		ace - Ameri lack, White		
10 (S W WAH 1215-0036 Jore, Maryland 21215-0036 Jose 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "naturel", or iteme 23a or 28a-1 show or other traumatic event, the Medical Experimental be notified at To Be Completed by Funeral Director	2 . 62	1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates:		2., 2,	Spec	T T1.	ite	
21215-0036 ed within 72 hours at Ngiene. Per Institute i' or in then 'naturel', or it, the Medical Exemple. Completed by F.	ומנים	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during mos life. DO NOT use retired)	st of working		16b. Kind of	Business/lr	ndustry	
within the man		Elementary/Secondary (0-12) College (1-4or 5+) 1 2 Warehouseman			Manu	fact	uring	
ind 2 be filed tal Hygind other event, in				irst, Middle, I				
arylanc should be f and Mental P a marked of umatic eve		Jerome P. Haulsworth, Sr. Ther	resa	Loret	ta Zi	tkev	itz	
Maryland 21 Maryland 21 d 2 should be filed w th and Mental Hygier tr is marked other it traumatic event, in		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Color of the Print)	er or Rural R	oute Number	, City or Tow	n, State, Zij	p Code)	
9, N l and tealth im 27 her tr	- 13-	Anita Clasing - Sister 8701 Baker Aver	nue,					
Baltimore, sermit. Peges 1 at Department of Hea Important: If Item my injury or other page.	1	20a. Method of Disposition 1		150	20c. Location Ba1ti			
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Baltimore, Mispermit. Pages 1 and 2 Dapartment of Health a Important: If tem 27 is any injury or other transpace.		PA. 2134 Will	low S	pring	Road	Fun 21	eral 222	dome.
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	s cardiac or re	espiratory arre	est,		Approximate Interval Bety Onset and D	ween
Physician		Immediate Cause (Final disease or condition resulting in death) a. QNOXIC brain injur	- 4				Oriset and C	704111
/Medical Examiner		Due to (or as a consequence of):						
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D, executed in and ial-transit		Cause. Enter Underlying Cause (Disease or injury that mittated events Cause. Enter Underlying Cause (Disease or injury that mittated events C.						
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K 68 antifica ling pl	-	IF FEMALE:						
Box eath cert attendin for use	2	23b. Was decedent pregnant in the part 13 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy				ate of deliv		'ear
P.O. I thet the de ed by the a detached f	326	1 Yes 2 No 9 Unknown Unknown						
res the signed be def		Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I.	l.		oaccouse co es 2 □ No		the cause of de	eath? Triknown
COrc				24a. Was a				
Division of Vital Records, P.O. Box to attending Physician: The law requires thet the death cert after death. Director: After this certificate hes been signed by the attending in by the funeral director, page 2 should be detached for use.	2			autops perforr	med? 2 No	prior to co death? 1 \(\text{Yes}	opsy findings a ompletion of ca 2 No	luse of
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/iSi	2	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office				nber or Rur	al Route Numi	ber,
Division c tel or Attending P is after death. el Director: After t ed in by the funers		4 Homicide building, etc. (Specify)		City or Town	n, State)			
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date an and manner stated.	nd place, and ath occurred	I due to the ca at the time, d	ause(s) and r ate and place	manner as s	stated. to the cause(s)	}
To the within To the complex	N A	29b. Signature and title of certifier 29c. License number		.2	9d. Date sign	ned (Month,	Day, Year)	
		D00580 D00580	82		4/2	8/06	>	
701		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-4			1		
0		6535 N-Charles North Pavillion Juites	50	UWSO	n, M.	D		
State Registrar		31. Date filed (Month, Day, Year) MAY 0 1 2006 32. Registrar's Signature						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day Month Year **Physician** MAE PANSY KESSELRING 1:05 P M 25. APRIL 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WESTMINSTER WESTMINSTER NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | | 3 / 28 / 1916 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2/2 F 174-01-3815 90 PENNSYLVANIA Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28e-f show traumatic evant, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No CARROLL TANEYTOWN MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21787 USA 34 FREDERICK ST. Itams 23a Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SHOE FACTORY MACHINE OPERATOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be finent of Health and Menta? I sut: If item 27 is marked of HARRY MONN OLIVE UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON 34 FREDERICK ST., TANEYTOWN, MD. 21787 JAMES D. KESSELRING, other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State LAKE VIEW MEM. PARK 4/29/06 ō = 0 ELDERSBURG, MD permit. Page Department of Importent: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) 21. Si natu a 1 Juneral 5 rvice Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. Approximate Interval Between Onset and Death 5 YFAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freary failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YEARS Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner be executed physician and the burial-transit Box 68760, Due to (or as a consequence of): The law requires that the death certificate attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DIABETES 1 ☐ Yes 2**X** No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending 1 X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral C 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi 4/26/2006 D0059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 A POOLE RD., WESTMINSTER, MD 21157 GOURISHANKAR NAGANNA 32. Registrar's Signature State Registrar

Physician Modical Examiner Sherry Iou Kendall Harris Hospics Shella Maris Hospics Stella Maris Hospics Stella Maris Hospics Stella Maris Hospics Timonium Saltimore Stella Maris Hospics Timonium Saltimore Stella Maris Hospics Timonium Saltimore 10c. Gay Twa In Under 21 Has In Under 21 Ha			1 - For State Registrar			l / Depar		Health and I	Mental Hy	_	06	13527
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Second Position of Check only one Ch	ysicien and burial-transit	Cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a	as a conseque	ence of):						
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25. Was case referred to medical examiner?	E 6	d by Ph	Part II. Other significant conditions	contributing to death	but not result	ting in the und	lerlying cause g	iven in Part I.				4.1
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29a. Certifier (Check only one) 29b. Signature and did to the cause(s) and manner as stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 4 2 4 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 27c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	ath. or: After t		1 Naturat 5 ☐ Pending 2 ☐ Accident investigati	(<i>Month, L</i>	njury Day Year)				28d. Describe t	now injury occ	urred	V
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarig- Mahmood, M.D. Timonium MD 21093	i Directo	Sertific	data in a	d 286. Place of	Injury - At hometc. (Specify)	ne, farm, stree	et, factory, office)	28f. Location (S City or Tox	Street and Nur vn, State)	nber or Run	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 Dulaney Valley K Tarig-Mahmood, M.D. Timon um MD 21093	24 hours Funera letely fille	dical ((Check only 2 Medical Exa	iminer: On the basis	s of examination	ledge, death on and/or inve	occurred at the stigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and r date and place	manner as s e, and due t	stated. o the cause(s)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarig Mahmood, M.D. State 31. Date filed (Morrier, Day, Year) 32/ Registrar's Signature 32/ Registrar's Signature	N) /-				DI	13725		4/3	24/8	2006
State 31. Date filed (Month, Day, Year) 32: Registrar's Signature // // 1000 /	2 ^v		Ton	completed cause o	of death (Item 2	23a) (Type, Pi	rint) 2	300.	Dula	ney	Va	lley Ro
	Sta	ate		32: Regi	strar's Signatu	ure		mon	um,	14D'	21	043

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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3. Time of Death

Reg. No.

2. Date of Death

Physician
/Medical
Examiner

For State Registra

1. Decedent's Name (First, Middle, Last)

Month Dav Year 401 APRIL EDWARD TROY LANE 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HAMMONDS LANE GENESIS ELDERCARE BROOKLYN ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 2 🗆 F Director 415.50.5639 67 MAY 26, 1939 TN Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No ANNE ARUNDEL GLEN BURNIE Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 MAPLE LN. NW 21061 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2□ No _1 ☐ Yes Specify Specify: 3₩Vidowed 4 Divorced XX WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 9 CAB CO. OWNER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I ont: if item 27 is marked o 2 VIOLA FREED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 MAPLE LN. NW GLEN BURNIE, MD 21061 KIMBERLY LANE **DAUGHTER** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) or permit. Page Department of Importent: if any injury or once. BAYVIEW CREMATORY 5.1.2006 BALTIMORE, MD 21. Signature of Funeral Service Lice FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW GLEN BURNIE, MD 21061 GREGORY FINK MO1148 Enter the issaal, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fail and List or hone cause on each line. Approximate Interval Between Onset and Death Immediate C _ e (Final disease or condition resulting in death) **Physician** Myocardia /Medical Due to (ores) consequence of): Examiner revere Sequentially list conditions, if any, leading to immediate cause. Enter Universing Cause (Disease or injury that initiated water) Due to (or as a consequence of) Examiner Due to (or s) consequen (a) f): The law requires that the death certificate be executed use as the burial-transit that initiated events signed by the attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 PNo Year Month Day 4☐Pregnant at time of death 5 Cher (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 **N**o 1 Yes 2 No 1 🗌 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2**(2)**(0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Death 28b. Time of funeral 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 😢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D53465 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAKWOOD ROAD 6/en Burnie Muneses WO 7845 31. Date filed (Month, Day, Year) 32 Règistrar's Signature State Registrar 2006

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sician		K

Physic /Med Exam

Funera Directo

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other treumatic event, its Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examine

within 24 hours after death. To the Funeral Director: After this certificete has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Registrar				Cer	uncate of	Dealli			Reg. No.		
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cal ner			e street and number ERAL HOSP			4b. City, Town, o	r Location of	Death		1 -	ounty of Death	
-3.2**	5. Social Security N		ex 7. A	ge (In yrs. la 42	ast birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bit 4-4-19	th 62 ear)	9. Birth WAS	hplace (State or Foreign writry) D.C.
	Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
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Director	10e. Street and Nu		D			10f. Zip Code	,			-	en of What Co	untry?
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þ	1 Never Marr	ied 2 Married	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Λ Year or Dates:	?]No	l I	f Yes, specify Cuban, Mexican, Puérto Rican, I □ Yes 2 No Specify:			Rican, etc.)		Black, White	a, etc. ACK
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To Be (17. Father's Name CARSE	(First, Middle, Last, LEE LUCA							(First, Middle EE KING		Sumame)	
	19a. Informant's N	ame/Relationship (Type, Print)			g Address (Street						ip Code)
	BRIAN 20a. Method of Dis		SR. (BROT			PIONEER]	DR. SE		, MD.	_	ation - City or	Town State
		Cremation 3	Removal from State	e Cé	emetery, cren RO CRE	natory or other pla	· 1		2006			MARYLAND
an/Medicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):											
Physician/M	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	! months? □ No	23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	y			2:	3d. Date of del Month	ivery Day Year
ģ	Turni Other digin	ficant conditions of	contributing to death	but not resu	ulting in the ur	nderlying cause giv	ven in Part I.			tobacco us		the cause of death?
Completed									24a. Was auto perf 1 🗆 Yes	psy ormed2		Itopsy findings available completion of cause of
Be	25. Was case refe examiner?		Hospital:			O#	100		(Check only			
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Medicai (29a. Certifier (Check only one)	Certifying Pl	nysician: To the bes miner: On the basis and manners	of examinal	wledge, death tion and/or in	occurred at the til vestigation, in my o	me, date and opinion, death	l place, a	and due to the	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
29b. Signature and titlle of certifier 29c. License number 29d. Date signed (Month, in the control of the con												
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ate rar	31. Date filed (Mor	nth, Day, Year)	32. Regis	trar's Signa	ture	/	<u> </u>					
	MAY	0 1 2006	AN CONTRACT	2 0	1							

Physician /Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		Please	Type or Print in Black			-	_	
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Physici /Medio		1. Decedent's Name (First, Middle, Las	Litanya Mar	shall		2. Date of Dea Month April	ath Day Year 23 2006	3. Time of Death
Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death		4c. County of Death	1,
		5. Social Security Number 6. Se	of Baltimore 7. Age (In yrs. last birtho		If Under 24 Hrs.	8. Date of Birt	N	/A
Funeral Director			☐ M 2 ☑ F 3 9 Yrs	Months Dave	Hours Min.	April	7,1967 Col	place (State or Foreign intry) MD
Maryland	ctor	10a. State 10b. County MD N	/A 10c. City, Town o					10d. Inside City Limits 1 Yes 2 No
th with the 23s or 28	al Director	10e. Street and Number 5526 Gwyn Oak	Ave Apt# 101	10f. Zip Code	21207		10g. Citizen of What Cou	untry? S.A
be filed within 72 hours after deeth with the Maryland tab Hygiene. d other than "naturel", or items 23a or 28e-f ehow event, I'm Medical Enaminar must be collified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Bl.	, etc.
ithin 72 hor ne. nen "nature nen "nature	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	ecedent's Usual Occupa Give kind of work done of fe. DO NOT use retired	during most of worki	ing	16b. Kind of Business/l	
ygien her th		12th	Ho	use Couns				2 Horizon
D 8 5 0	To Be	17. Father's Name (First, Middle, Last) Carl B. Marsha			Patric	ia Har		
		19a. Informant's Name/Relationship (7 Patricia Brown	/Mother 110	2 Sedgewo	od Rd Ba	altimo	er, City or Town, State, Zi re Md 212.	
permit. Pages 1 and Deportment of Heali Importent: If Item 2 eny injury or other 2008.		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State Cemetery,	isposition (Name of crematory or other place)	14/2	9/06	Baltimo	a Md
permit. Depertiment import		21. Signature of Funeral Service Cicen	S 00	22. Name and Address	chai	tman-H	arris Fundaltimore 1	eral Home
		shock, or heart failure. List only	lications that caused the death. Do not	enter the mode of dying	g, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between
Physician)	Immediate Cause (Final disease or condition resulting in death)	a. Hypoventi lati	on Syndrom	۹.			Onset and Death
/Medical Examiner		Tooling in doday,	Due to (or as a consequence of).	: /				
3	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Hypoventilati Due to (of as a consequence of) b. Obstructive Due to (or as a consequence of)	Sleep April				
s be executed sicien and burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of).					
ate be ex hysicien the burial	<u>e</u>		d.	· 				
Attending Physician: The law requires that the death certificate trident. ector: After this certificate hes been signed by the attending physic by the funeral director, page 2 should be detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of pregnancy 1 Live bith 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive	very D <i>a</i> y Year
ires that the de signed by the a d be detached t	þ		ontributing to death but not resulting in the		en in Part I.		obacco use contribute to	
w require been sig should b	ompleted	Conges	TIVE PERTY FAITURE			24a. Was		
rsician: The lar s certificete hes lirector, page 2	O					autop perfor 1 Yes	rmed death?	opsy findings available ompletion of cause of
siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othe	26. Place of Death			
iding Phys th. : After this funeral di	 -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	ne of 28c. Injury	4 ☐ Nursing Hor		dence 6 Other (Speci now injury occurred	fy)
al or Atter after dea I Director d in by the	Certification;	3 Suicide 6 Could not be determined	1	, street, factory, office	-	28f. Location (S City or Tow	Street and Number or Rur vn, State)	al Route Number,
To the Hospital or Atlanding Ph within 24 hours after death To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Cartifying Ph 2 Madical Exam	/sician: To the best of my knowledge, d iner: On the basis of examination and/o and manner stated.	death occurred at the time or investigation, in my op	e, date and place, a pinion, death occurre	and due to the ded at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Month,	Day, Year)
			7.0.	∆ 05	19		April 23, 2	006
7		30. Name and address of person who o	completed cause of death (Item 23a) (Ty	rpe, Print)	0 4			
Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Belyedere	Boltimore	MD 2	21215	
Registr		MAY 0 1 2006	732. Registrar's Signature					

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Carol Allan, MD

31. Date filed (Month, Day, Year)

MAY C

Assistant Medical Examiner

32 Registrar's Signature

111 Penn Street, Baltimore, MD 21201

David Michael O'Beirne

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and M	Mental Hygiene

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		l- For State Registrar			C	ertificate (of L	Death			R	eg. No.	G U	UU	4	0000
Physicia	_	Decedent's Name (First, Midd	le,Last)							2	Date of Dea Month	ath Day	Year	3.		of Death
Medical Examir	ner	DAVID MICHAEL) BE	IRNE							April 25, 2	2006			1220) hrs
		4a. Facility Name (if not institution			imber)			City, Town, or Li	ocation o	of Death			County of			
		1143 Ingate Road						Halethrope					altimore			
Funeral	\neg	5. Social Security Number	6 Sex		7. Age (In yr:	s last birthday)	Ţ	If Under 1 Year	-		8. Date of Bi	rth (MM/E		9 Birthp Foreign	olace (S	itate or
Director		230.60.2832	1 X	M 2 F	60) Y	rs	Months Days	Hours	Min.	APRIL	22,	1946	Count	try)	VA
	H	Usual Residence of Decedent		_												
any	ı	10a. State 10b. County			10c. C	ity, Town or Loc	ation	1						10	0d Insi	de City Limits
<u>*</u> .	.	MD BALTI	MUBE	,	111/	LETHORE	F							1	1 Y	es 2 χ No
Aaryland 28a-f show i at once.	황	10e. Street and Number	IOICI		1111	mbriton.		10f. Zip Code				10a Cıtiz	en of Wha	t Country	y?	
or 28	Director	1143 INGATE RD						2122	7				US		,	
th the Mary 23a or 28a notified at				40 M D	and and Education	110 140 1				-i-0 / 0	- 7 - V N				- I-dia	Disele
th wi	Funeral	11. Marital Status 1 Never Married 2 M	arried	Armed F	cedent Ever in orces?			Decedent of Hispa , specify Cuban, i				o-	 Race - White, 		n Indiai	т, втаск,
or it	齓		- 1	1 Yes	2 N	· I	¬	. V				Ĭ		WHIT	יגי	
after iner	<u>a</u>		i	If YaX Give Year or Dates:		1		es 2 X No					opcony.			
hours afte 'natural" Examine	ba	15. Decedent's Education (Spe						Usual Occupation t of working life. [16b. K	ind of Busi	ness/Indi	lustry	
6 n 72 h	Completed	Elementary/Secondary (0-12)		College (*	1-4 or 5+)		' A T	ESMAN				ITM	DUSTR	TAT	CON	ID A NIV
5-0036 led within 72 Hygiene I other than	ᇍ	12		1			AL							.LAL	COP	LEAN I
5-C		17. Father's Name (First, Middle	, Last)						_	's Name (F	First, Middle,	Maiden (Surname)			
2121 uld be fi Mental I marked c event,	å	unk						uı	nk							
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traumatie event, the Medical Examiner must be notified at once	မ	19a. Informant's Name/Relations	ship (Ty		***************************************		_	ddress (Street								e)
and 2 shou tealth and I tem 27 is retraumatic		LISA HARRIS		D <i>E</i>	AUGHTE	880)1	WATERFI	ԵՐՈ				au die			8.U
ore, MC es 1 and 2 s of Health a If item 27 her traum	- [20a. Method of Disposition		-1		 b. Place of Disp crematory or 		on (Name of ceme r place)	etery,		Date	20c. L	ocation - C	ity or To	own, Sta	ate
Baltimore, permit Pages I a Department of He Important: If ite			_	Removal fr						1. 20	2006	_	AT 17M	TT A		
it. P.	-	4 Donation 5 Other S 21. Source of Funeral Services		ee /	JSI	HERWOOD 22			of Facilit		9.2006	5	ALEM,	VA_		
Baltimo permit Page Department of Important: injury or oth		de monsus ():	1	of :	<i>ک</i> ے۔۔۔۔۔		ΪŅ	ne and Address of FUNER	AL H	OME,	P.A.	DATT 12	MD	2106	1	
	-	23a Part I. Enter the disease, o	LNK compli	cations that o	MO1148	ath Do not ente	r the	CRAIN I	HW I	ardiac or r	espiratory ar	rest sho	ck or hear	2100		imate Interval
Physician /Medical		ailure. List only one cause	on eac	ch line.						A 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	oopiratory ar	1001, 0110	or, or nour			en Onset and
xaminer		Immediate Cause (Final disease	_				dio	vascular Dise	ease							Death
		or condition resulting in death)		ue to (or as a	consequenc	e of):										
,		Sequentially list conditions,	b													
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		de to (or as a	a consequenc	e 01).								_		
	am	(Disease or injury that initiated events resulting in death) Last	C	oue to (or as a	consequenc	e of):								\rightarrow		
nted d ansit		oromo roodining in doddiny Edoc	d.													
760, ficate be executed g physician and s the burial - transit	n/Medical	UNPENDED		AMENDED												
so, te be sysici buri.	ed	IF FEMALE:		22c If you	outcome of p	reanancy						234	I. Date of d	elivery		
8760, tificate be ng physic as the bur	2	23b Was decedent pregnant in t	he	1 Live I			Fetal	death 3	Ectopi	c pregnan	су		Month	Day	y	Year
Ox 68; ath certifi attending or use as 1	cia	past 12 months?		4 Pregr	nant at time of	f dooth -		r (Specify)								
Box 68 ne death cert r the attendir	ysi	1 Yes 2 No 9 Ur	known	g Unkn	own											
P.O. Box 6 res that the death ce signed by the attend be detached for use	Physicia	Part II. Other significant condi	tions	contributing t	o death but n	ot resulting in th	e und	derlying cause giv	ven in Pa	art I.	23e. Did t	obacco i	use contrib	ute to the	e cause	of death?
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the start cleath. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	þ										1 Ye	s 2	No 3	Probat	oly 4	✓ Unknown
ords, w require us been si should b	Completed			-	*						24a. Was	an	24b. W	ere autor	psy find	lings available
OFC aw re as be	Be										auto	psy ormed?	pri			of cause of
Che la	e l										1 Yes			✓ Yes		2 No
tal Recting: The certificate ector, page		25. Was case referred to medic	al					26.Place	of Death	(Check or	nly one)					
Vital Recc nysician: The lav this certificate ha I director, page 2	B	examiner? 1 ✓ Yes 2 No	I ^H	ospital: 1	Inpatient 2	ER/Outpatie	ent	3 DOA	Other ₄	Nursing	Home 5	Reside	nce 6 🗸	Other S	Scene	
of Ving Phy	2	27. Manner of Death		28a. Date	of Injury h, Day,Year)	28b. Time o	of Inju	ury 28c. Injury	at Worl	2</th <th>8d. Describe</th> <th>how inju</th> <th>ry occurred</th> <th>t</th> <th></th> <th></th>	8d. Describe	how inju	ry occurred	t		
adiny	틸	1 Natural 5 Per	iding	(Monti	n, Day, Year)			1 Y	es 2	No						
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lor after d in Dir	뛻		ald not be	e		tt nome, rann, si	1001,	ractory, office bu	ilidilig, c	10.	or Town,		na Namber	oi itulai	Noute	Number, Gry
Spita spita nours neral	Certification:	4 Homicide	Jiiiii Cu	(Specify,						- 1						
e Ho n 24 } e Fu		Check only	-		-			d at the time, dat								.\
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciau: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transi	Medical	2 🖳		and manner		in and/or investi	yatio	n, in my opinion,		curred at	une ume, date					
	Ž	29b. Signature and title of certif	ier ,		10		_	29c, License	number			29d. [Date signed	(Month	n, Day,	Year)
		Que 52			MD			O.C.N	1.E.			Apri	1 26, 200)6		
		30. Name and address of perso	n who c	ompleted cau	ise of death (I	tem 23a)							-			
10					Examiner		Str	reet, Baltimoi	re, MD	21201						
	ate			32 4	egistrar's Sigi		-	AP m							_	
Regist		31. Date filed (Month, Day, Xear	1 20	06	100000	At A	0.1	a.								

			For State	State of Maryland		artment of H			6.01	16	13533
			Registrar 1. Decedent's Name (First, Middle, Last)		001	timoato or i	Doutin	2. Date of Dea	Reg. No.		3. Time of Death
т	Physici	an	- 1 33 ()	Ortiz-Cuber				Month	Day	Year	1515 CM
	/Medic		Isabella (nmn) 4a. Facility Name ff not institution, give s		<u> </u>	4b. Cîty, Town, o	r Location of Death	ynil_	4c. County	of Death	113.20
/	Examin	er	The Sobre Hon	Wine Hos	41	Bull	TMINE	Pity			
	Funeral		5. Social Security Number 6 Sex	7. Age (Ip) yrs. It	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h Vonsi	9. Birthp	place (State or Foreign
	Director		220-73-4932	M 20XF	Yrs.	Months Days	Hours Min.	Dec. 1		Mary	
	D.		Usual Residence of Decedent	10- 64							IOd Incide City Limite
	anylar	<u>.</u>	10a. State 10b. County		, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 XNo
	Ba-f	Directo	Maryland Harford	APG		Trace and			10- 0%	Mb - 4 C	
	with th		10e. Street and Number			10f. Zip Code			10g. Citizen of	what Cour	ıtıy :
	death with the Maryland me 23a or 28a-f ehow Linual be notified at	Funeral	2511 Ocean Court	12. Was Decedent Ever in U.	S 13 1	21005	lispanic Origin? (Sp	ecify Yes or No-	USA 14. Bac	e - Americ	can Indian.
	item item	Ę.	11. Marital Status 1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No	. 10.	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		ck, White,	
8	urs at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specif	v: Wh	nite
Š	filed within 72 hours after Hygiene. vther then "neturei", or ite ent, the Medical Examire	ted	15. Decedent's Edu	cation		dent's Usual Occup	ation during most of work	ring	16b. Kind of B	usiness/Inc	dustry
215	hin 7	pje	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of work	ung	110		
2	d wit	Completed	0		1	LIA			NIH		
2	be filed tal Hygi d other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam			•	
₹ Z	should be filed within 72 hours after death with the Marylan and Mental Hygiene. • marked other then "natural", or iteme 23a or 28a-f ehow immatic event, the Medical Examinar must be notified at	ဥ	Luis Adan Orti					a Del-C			
Maryland 21215-0036	2 2 2 2		19a. Informant's Name/Relationship (Ty		V202300	0.07	and Number or Rui		1982 - 1922 V <u>1</u> 972	-	(Code)
	1 and 1 Health em 27 ther tr		Luis A. Ortiz / F			Ocean Ct	Apt. A	APG, I	MD 2100 20c. Location		own. State
و	00		1 ☐ Burial 2 ☑ Cremation 3 ☐ R			matory or other place	corp. 4-29	9-06			land 2005
Baltimore,	if. P.		4 Donation 5 Other (Specify) 21. Sign Me Funds Service Icense						TOWSOIT,	PICILY	Taria
e C	permit. Pag Depertment Important: fi any injury o		VIKII		Mo		neral Hon		don Mo	1	J 21000
	_		23a Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	n. Do not ent	ter the mode of dyir	bury Road	or respiratory ar	rest,	гутап	Approximate
ı			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	and the same of						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	- ^					Sacrys
	Examiner			Pulmova	nl I	Insuffi,	ciency				4 months
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	cuted nd ransi	Examiner	that initiated events	: Kenal I	MSU	tiuen	M				4 months
Ö,	e exe		resulting in death) Last	Due to (or as a consequ	zence of):	200 010 - 1	- A Arc	10000	100		2 March F
8760	Attending Physician: The law requires that the death certificate be executed reach. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dicai		MUNITE		ongenit	TUL AL	DIVION	167		11/10/11/0
9 ×	that the death certific ed by the attending p detached for use as	0	IF FEMALE:	3c. If yes, outcome of pregna	nev)			224 Do	to at dalim	
Box	atten for us	ian	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	□Ectopic pregnancy □ Other (specify) _	1			ite of delive onth	Day Year
P. 0.	the de	by Physician/M	1 □ Yes 2 No 9 □ Unknown	9□ Unknown	Juli 0 2	_ ou.or (opcony) _					
	that ned b	y P	Part II. Other significant conditions con	ntributing to death but not resu	alting in the u	ınderlying cause gıv	ren in Part I.	23e. Did to	obacco use con	tribute to th	he cause of death?
Sp	quires tha n signed uld be dei	D D	PUlmonary H	ypertens!	DN			101	Yes 2 No	3 ☐ Prob	pably 4 □Unknown
000	s been si	Completed	Pan-resistin	F bseuda	MOV	ras		24a. Was		Were auto	psy findings available
æ	The law te has age 2 :	E	Fatra Ventric	ILLAK DEM	MVV	10180-		autop perfo 1 Yes	rmed2	death?	mpletion of cause of 2□ No
<u>E</u>	rtifica	Be C	25. Was case referred to medical	O TOO		3	26. Place of Dea		7		
>	nysic nis ce I direc	To	examiner? 1 Tes 2 No	fospital: 1 > inpatient 2	ER/Outpatier		4 🗆 Nui sing n	ome 5 Resid	dence 6 □Oth	ner (Specif	γ)
20	ng Pl Merti		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe h	how injury occur	red	
<u>s</u>	Attendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	COA Leastine /	Carrada - data -		10
Division of Vital Records,	ે કું કું હ	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, rarm, st	reet, factory, office		City or Tox		er or mura	al Route Number,
_	ours a		29a. Certifier Certifying Phy	sician: To the best of my kno	wledge, deat	th occurred at the tir	me, date and place	, and due to the	cause(s) and m	anner as s	tated.
	To the Hospital or within 24 hours after To the Funeral Directions completely filled in the comp	Medical		ner: On the basis of examination and manner stated.							
	To th within To th comp	Me	29b. Signature and title of continue			29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
	4.		1/1/2	-MD		D	006/16	56	April	26.	06
	11		30. Name and a free of person who co	ompleted cause of death (Item	23a) (Type,	Print)	Co oh	+ 0.1	1 000 0	LAT	71787
	7		Kentel (505)	MD (d)	UIVA	ALM MOI	ITC SIYEE	1, DU	myore	NIL	1001
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	LUI B						
	9.0.		MAY 0 1 2006	KARTELAN PRO S	1						

		1	1 - For Amend Item 1 Registrar	State of Marylar per Dr., G85	nd / Dep 5 ,05 /0	partment of l	Health and M <i>Death</i>	ental Hyg	jiene •g. No: 006	13534
	Physicia		1. Decedent's Name (First, Middle, Last)	George	Parke	r		2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic		Gara p	White -				April	22 2006	7=45pm
)	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	ath
	Francis		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday	If Under 1 Year	Dunder 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
	Funeral Director		213-32-4533	M 2□F 68	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day OCT 12	2°, 1°937	MD MD
	D > 0		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ity, Town or t	onation				10d. Inside City Limits
	Aaryia	٥	MD N/			timore				1 Yes 2 No
	the h	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Whal C	ountry?
	be filed within 72 hours after death with the Maryland ital Hygiene d other than "natural", or lteme 23a or 28a-f ehow event, the Medical Examinal must be notified at	0	6 Duke of Winds	or Ct # T4			21207		USA	
	deat	Funeral	11. Marital Status	Was Decedent Ever in L Armed Forces?	J.S. 13	. Was Decedent of I	Hispanic Origin? (Spe an, Mexican, Puerto	crfy Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
Š	or its		1 Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give		1 ☐ Yes 25 No		, , , , ,	Specify: B1	1370
3	hour tural'	ed b	3 ⊈Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	16a. Dec	edent's Usual Occup	pation		16b. Kind of Business	s/Industry
9500-6121	within 72 ene. than "nal	piet	(Specify only highest grade Elementary/Secondary (0-12)		(Giv	e kind of work done DO NOT use retire	during most of working)	ng	Tractor	
7	giene giene r th	Completed by	12th		Mus	hroom Tr	ansporta	tion	Driver	
2	be filed ital Hygid of other event, I	Be	17. Father's Name (First, Middle, Last) George B. Parke	r Sr.			18. Mother's Name Elsie	(First, Middle, i		
<u>~</u>		၉	19a. Informant's Name/Relationship (Type		10b Ma	line Address (Ctross			r, City or Town, State,	Zin Codel
Maryland 21	Te L		Angela Legon /						ore MD 21	
ē,	item 27		20a. Method of Disposition	20b.	Place of Disp	position (Name of	cal C		20c. Location - City o	
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			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	ith. Do not e	nter the mode of dyl	ng, such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cone	A 0	f Empl	ysome			
	Examiner				querice oi).	. /				
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
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/89	tificate ng phys as the	edicai	d							
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E S	sicien: Th certificete rector, pag	a	25. Was case referred to medical				26. Place of Death			s 2□No
<u>></u>	g is 2	To B	examiner? 1 □ Yes 2 No	ospital: 1 Inpatient 2] ER/Outpati	ent 3 DOA Ott	her		ence 6 □Other (Spe	ecify)
<u> </u>	ding Ph h. After th funeral		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo		28d. Describe h	ow injury occurred	
Division	or Attending ifter death. Director: After in by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm]Yes 2□No	Of Location (S	treet and Number or F	Burgi Pouto Number
<u>≥</u>		Certification:	4 Homicide determined	building, elc. (Speci	ify)	street, factory, office		City or Town		ioral ricale ricinoes,
	e Hospital or 24 hours afte e Funeral Dir letely filled in		29a Certifier 12 Certifying Physical Check only 2 Medical Examin	ician: To the best of my kn er: On the basis of examin	owladge det	ath occurred at the ti	The date and place i	and due to the e	ause(s) and manner a	s stated,
	To the Hos within 24 h To the Fur completely	Medical	one)	and manner stated.	water and/of	29c. Licen:				
ı	or wit		29b. Signature and title of certifier	/					9d. Date signed (Mon	
	(2)	1	30. Name and address of person who co	moleted cause of death (Ita	m 23a) /Tun		15974		AM EZ,	2406
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Registrar DHMH 17 Rev 1/2001

State

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			For State Ragistrar	State of	Marylan		artment of				ene g. No.	106	1353	35
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			Casey House MC 5. Social Security Number 6		y Hosp		Rockvi		24 Hrs. 8 (Date of Birth	MOI	ntgome	ery place (State or i	Foreign
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-	how date	_	10a. State 10b. County			y, Town or Lo	cation						10d. Inside City 1 Yes 2	
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93	er', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		1 □ Yes 2 🔼 I	No Specify:	•		Sp	ecify: Bla	.ck	
21215-0036	within /2 nouts atter death with the Maryland ene. Then "naturel", or iteme 23e or 28e-f ehow fre Modical Exeminer must be notified at	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Oc kind of work do DO NOT use re	cupation one during mos	at of working	1	6b. Kind	of Business/Ir	dustry	
2	70	ig m	Elementary/Secondary (0-12)	College (1-4	4or 5+)		DO NOT use re ESSOT	tired)	· ·	T	Iouza	מנו הי	iversi	+ + + +
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and		Be C						Myrt		Gary	2001 30	mame _/		
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ē,	of Hea of Hea fitem rothe		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other		Date			ion - City or T		
altimore,	Pages nent of int: if it iry or o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		tate :	-	l Mem C		s 4/1	7/06G	ooci	land	Co., VA	Α.
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<u>}</u>	nysic his ce	၉	1 ☐ Yes 2 No		patient 2		IL 3 DOA						Hospic	ce
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:	n 24 h	Medicai	(Check only 2 Medical Ex	aminer: On the bas	sis of examina er stated.	tion and/or in	vestigation, in n	ny opinion, dea	ath occurred a	t the time, da	te and pla	ace, and due t	o the cause(s)	
i	withii To the	Σ	29b. Signature and title of certifier				29c. Lic	ense number				igned (Month,		
)			I Chuke for	2_				2452			_	. 12,	2006	
	10		30. Name and address of person wi	no completed cause	of death (Item	n 23a) (Type,	Print) Dr.	Cnitr	a Raj	agopa	1			
	1		6001	11177 -			•							1
	Sta	10	6001 Muncaster 31. Date filed (Month, Day, Year)	Mill R	oad Ro	ockvi	lle, M		350					

		1 - For State Registrar	State of Marylar		artment of H			ene 0 0 6	13536
Physic /Medi Examir	cal	Decedent's Name (First, Middle, Las Olive C. Peruzzi 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	2. Date of Death Month April 27	4c. County of Death	3. Time of Death 7:30 PM M
Funeral Director		7929 St. Bridget 5. Social Security Number 6. Sr 220-50-6799 1 Usual Residence of Decedent		. last birthday) Yrs.	Dundalk If Under 1 Year Months Days	If Under 24 Hi Hours Mi		Baltimore 9. Binhp Coul 41 Engla	place (State or Foreign ntry) and
the Maryland 28a-f ehow	ector	10a. State 10b. County Maryland Baltimo		bunda			10	g. Citizen of What Cou	10d. Inside City Limits 1 Tyes 2 No
DEMILIIIOTE, INIGITYIGITIC ZIZIS-UUSO permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or itema 23a or 28a-1 ehow any injury or other treumatic event, ite Madical Examinar must be notified at once.	by Funeral Directo	7927 St. Bridget 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Lane 12. Was Decedent Ever in Under Street		21222	ispanic Origin? In, Mexican, Pue Specify:	(Specify Yes or No- erio Rican, etc.)	USA 14. Race - Americ Black, White, Specify: Whi	can Indian, etc.
l X I X I 3-UU led within 72 hour lygiene. her then "natural nt, its Medical E.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ucation	16a. Dece (Give life. Homer	dent's Usual Occup kind of work done o DO NOT use retired naker	during most of w	orking D	6b. Kind of Business/In	
aryiario	To Be	17. Father's Name (First, Middle, Last) Thomas Woodward 19a. Informant's Name/Relationship (7)	•		_	Barbara and Number or I	Rural Route Number,	City or Town, State, Zip	
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To the Hospital or Attending Physician: The taw requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past +2 pronths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
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SICE OF V tending Physic feath. tor: After this ce the funeral direct	ပို	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	4 🗀 Nursing	Home 5 Residen 28d. Describe how	ce 6 Other (Specific injury occurred	Y)
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To the Hos within 24 h To the Fun completely	Medical		iner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my of	oinion, death oc	curred at the time, dat	e and place, and due to	o the cause(s)
87		30. Name and address of person who	completed gause of death (Ite		Print) Let C	5408 Batto	md. 212	14 28 20	20%
Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 1 20	32 Registrar's Sign		and I	1500110	V. L. Z	· []	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per fh 2855 5-10-06 vt.
State of Maryland? Department of Health and Mental Hygiene
State Amend Items#5&20c per FH G855 5/23/06 CC
Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 1:39 P April 28, 2006 Ronald Robinson 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore 10 Ouarterwood Court #A Woodlawn 8. Date of Birth (Month, Day, Year) March 14, 1957 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1**⊠**M 2□F Months Days Hours 49 Yrs. Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Woodlawn Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 10 Quarterwood Court #A 21202 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 9 Elementary/Secondary (0-12) College (1-4or 5+) **Apartments** Maintenance Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Juanita Harris John Walker Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 900 St. Paul Street 3rd Floor, Baltimore, MD 21202 Gary A. Robinson - brother 20b. Place of Disposition (Name of Meadowridge Genetery Maryland Veterans Cem May 4, 2006 Crownsville, Maryland 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteniosclenotic 5 year & Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 X No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Iteme 23s or 28s-1 show any injury or other traumatic event, it a Medical Examinar must be notified at once.

use as

The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital Hospital or Attending Physician:

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fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. autopsy performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number D18666

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

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31. Date filed (Month, Day, Year) State Registrar

Militello 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trimble 1+:11 CT. Luthen: lle, Maryland 21093

Physician /Medical Examiner Sinai **Funeral** Director 72 hours after death with the Maryland 10a. State 28a-f ehow if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at MD. Director Completed by Funeral 11. Marital Status filed within 7 Hygiene. KNOUTH -12-Maryland Be 2 should be finance and Mental Finance is marked of permit. Pages 1
Depertment of Hr
important: if iter
eny injury or oth 4 Donation **Physician** /Medical Examiner Box 68760

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 8:52AM 24, ALVIN RHYNE 200 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Citu DF Hospital Baltimore Baltimor N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 1**X**XM 2□ F 214**-**56-4669 55 10-7-1950 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 FALKIRK RD. 21239 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STATION ATTENDANT -0-MTA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JAMES RHYNE SR. THERESA McGOWAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN BARNES (FRIEND) 4228 PIMLICO RD. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State S □ Other (Specify) KING MEMORIAL PARK 4-29-2006 BALTIMORE, MARYLAND 21. Signatura di Austral Service bicensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. Metabolic Acidosis Approximate Interval Between Onset and Death Due to (or as a consequence of): na ee tai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 ☐ Yes 2 No Hospital or Attending Physicien: ours efter death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the 29b. Signature and title of certifier 29c. License number lndem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) to uende Eugenie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar CAR MAY 0 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Division of Vital Records, P.O.

			. For	se Type or Print in E State of Marylan	d / Depa	artment of H	lealth and N		_	e. . 13539
			1 - State Registrar		Cei	rtificate of	Death		g. No.	
	Physicia	an	Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Ye	3. Time of Death
	/Medic	al	Evelyn Rob 4a. Facility Name (If not institution,			4h City Town o	r Location of Death	4	26 6 4c. County of 1	
	Examin	er	~4	Davale HOSP	105	1225	2015		0	HIMORE
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3-28-1		Birthplace (State or Foreign Country)
	Director		217-34-5578	1□M 2€□F 72	Yrs.	Months Days	Hours will.	3-28-1	934	WV
pu	3		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
Maryla	ob and	5	MD Balti	more M	iddle	River				1 ☐ Yes 2 ☐ No
the	28a-	rect	10e. Street and Number			10f. Zip Code		10	0g. Citizen of Wha	
death with the Maryland	23e or 28a-f ehow unt be notified at	ai Di	2226 Coraltho	rn Road		21220			USA	
9		by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Si an, Mexican, Puerto Specify:	Decify Yes or No- Decify Yes o	Black,	American Indian, White, etc. Vhite
3-0030	atural cal Ex	edt	15. Decedent	s Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	ess/Industry
. 1 . 1	A Pu	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	d) most of wor.	king		
V D	Hygiene other the	Соп	8		Н	omemake		- Approximate the second secon		Home
	od oth	Be	17. Father's Name (First, Middle, L	.ast)				ne (First, Middle, M		
	nd Menta marked matic e	မ	Unknown 19a. Informant's Name/Relationsh	in (Type, Print)	19b. Maili	ng Address (Street		n Spark ral Route Number		ite, Zip Code)
Mary	E . 5			nson - Husban		-				
Baltimore,	Department of Health important: if item 27 any injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 ☐Removal from State	Place of Dispo cometery, crea	osition (Name of matory or other pla	ce)	Date	20c. Location - Cit	y or Town, State
Baltif	oortan oortan injur		21. Signature of Funeral Service t		VVIEW 2	Cremat 2. Name and Addre	ss of Facility Br	adlev-A	shton F	uneral Home
ä	9 = 8		Bitha tut		2	134 Wil	low Spr	ing Rd,	21222	and all mome
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused the deat only one cause on each line.	th. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arri	est,	Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)	a acute	MI					
	Medical xaminer		resulting in deatily	Due to (or as a consec	quence of):					
Ш		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	juence of):					
petition	nd transit	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events	+ HUDER	chal	esterin	15 mia			
		Exa	resulting in death) Last	Due to (or as a consec						
68760 (Gate back	ysici he bu	Icai		d						
ž pi	ling pl	Med	IF FEMALE:	23c. If yes, outcome of pregna	2004				204 0-4-	Adala
Records, P.O. Box 68/60,	been signed by the attending physicien ar should be detached for use as the burial-t	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	
7. P. P. P. C. P.	ned b	y P	Part II. Other significant condition	ns contributing to death but not res	sulting in the u	underlying cause gr	ven in Part I.	23e. Did tol	bacco use contribu	ute to the cause of death?
	on sign	ed b	COPD					1 □ Y	es 2 No 3	□ Probably 4 □Unknown
O လ	s bee 2 sho	Completed	CHA					24a. Was a	n 24b. We	re autopsy findings available in to completion of cause of
	ete hes page 2	mo	diabe	LES				perform 1 ☐ Yes	med? dea	ith? Yes 200 No
Vital Records,	certificete rector, pag	Be	25. Was case referred to medicat examiner?			04		ath (Check only on	e)	
- 0	this c	٩	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☑ 28a. Date of Injury	ER/Outpatie	III JUDON		ome 5 Reside	ence 6 Other	
5 8	Viter uner	tion	27. Manner of Death 1 Natural 5 Pendin investig	g (Month, Day Year)	Injury	Wo	rk?]Yes 2 ∐No	Edd. Booking III	ow injury codamo	
on of	E	CTS.	2 Accident investig	not be 280 Blace of Injury . At h	nome farm st	treet factory office				
Division of Vita	after death Director: /	ertifica	4 Homicide determ	ined 28e. Place of Injury - At h	fy)	reet, factory, office		City or Town	n, State)	or Rural Route Number,
Division of	124 hours after death. Funeral Director: After letely filled in by the funer	edicai Certification:	4 Homicide determ	g Physician: To the best of my kn Examiner: On the basis of examinand manner stated.	fy) owledge, dea	th occurred at the ti	me, date and place	, and due to the c	ause(s) and mann	er as stated.
Division of	within 24 hours after death. To the Funeral Director: After this certificate he bompletely filled in by the funeral director, page	Medical Certifica	4 Homicide determ	g Physician: To the best of my kniexaminer: On the basis of examinand manner stated.	fy) owledge, dea	th occurred at the tinvestigation, in my	ime, date and place opinion, death occurse number	e, and due to the corred at the time, d	ause(s) and mann late and place, and	er as stated. d due to the cause(s) Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

DR. SUNIL Ohuja 31. Date filed (Month, Day, Year)

MAY 0 1 2006

9000 FRanklin Squaled R. Baltmore, MD 81237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** KUYSER 8,10 P, M. XEPHANIE APRIL 2006 DYNEHE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAITIMUNE
If Under 1 Year If Under 24 Hrs.
Hours Min. GILCREST NUKSING Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 3 F YES. 669 215 70 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturs!', or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No BA 1.4mon 8 Director MID 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.P. 21231 STREEL 2036 1 frmont Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ To If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Blacic 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) JudgE DISTRICT COURT BAILMING CIA Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17_Father's Name (First, Middle, Last) KebinBand noystex 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BAITIMENE MD 2/23/ & BAILMERS If 2036 HRCE 11a MCYSER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 106 Acketus 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility BEHS 21. Signature of Funeral Service Licenses Baltimong MD 2/2/3 Sottruo CATULINE ST Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) m Physician rears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No director, page 2 of Vital 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 Yes 2 No this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (cirtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and mamner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier Apr. (25,2006 125201 N. Chales St. Balto, and 2120& 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) BINC 6701 31. Date filed (Month, Day, Year) MAY 0 1 32 Registrar's Signature

State

Registrar

1 2006

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DOROTHY 6:50 P M SMITH APRIL 26, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M Days Hours XX APRIL 21, 1937 Director 216.32.9661 69 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director GLEN BURNIE ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 MARLEY NECK RD. 21060 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XX o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No XX Specify: Specify: 3 ₩idowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. MOTOR VEHICLE ADMIN. Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK MARYLAND othar traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HELEN SHANEY ၉ HARRY LESSNER and l 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health ar nt: If item 27 Is 1 y or other tree JEAN GILBERTO DAUGHTER 505 BALTIC AVE. BROOKLYN, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBuriai 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 4.29.2006 BALTIMORE. MD 21. Signature of Funeral Service Licenses FINK FUNERAL HOME, P.A. GREGORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the *see e, *r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, *r heart failum. List soly one cause on each line. Approximate Interval Between Onset and Death Immediate Ca. se (Final disease or condition resulting in death) ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. anding physician use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 X No 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Yes Yes 2 🗌 No 3 Probably 4 Unknown been si should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? certificate 1 Yes **X**☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 5 Pending 1X Natural Injury death. 1 ☐ Yes 2 ☐ No investigation nours after death neral Director: / / filled in by the f 2 Accident 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 0 00 56 420 4.26.2006 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person with confinence cause of the court of t 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State MAY 0 1 2006 Registrar

ORIGINAL

		-	1- For State of Maryland / Departm	ent of Health and Mate of Death	Reg.	Lu U U U	13542
	Physici	an	1. Decedent's Name (First, Middle, Last) Michael Suarez		2. Date of Death	Pay 2006	3. Time of Death 10:30 PM
	/Medic Examin		,	City, Town, or Location of Death Baltimore	7,011	4c. County of Death	
Ī	Funeral Director		St. Agnes Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U Mor 217-30-5350 1 ☒ M 2 ☐ F 71 Yrs.	nder 1 Year If Under 24 Hrs. ths Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Coui	place (State or Foreign ntry)
	Maryland 8-f ahow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Catonsvil			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	4 within 72 hours after death with the Maryland liene. r than "natural", or Iteme 23a or 28a-f ahow the Medical Exeminer must be mailfied at	rai Director	121 Stonewall Road	f. Zip Code 21228 Recedent of Hispanic Origin? (Spe		USA 14. Race - America	
920	urs after de al', or Item Examiner o	by Funeral	Armed Forces? If Yes,	es especify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
1215-0	within 72 ho lene. rthan "natur the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Usual Occupation of work done during most of work OT use retired) Ance Supervisor	ng	. Kind of Business/In	
Maryland 21215-0036	be filed htal Hyg ed othe event,	To Be Co	17. Father's Name (First, Middle, Last) Daniel Suarez		(First, Middle, Maid	City Gover den Sumame)	nment
Mary	d 2 sh h and 7 is m traum			dress (Street and Number or Rura			
Baltimore,	Pages 1 and 2 nent of Health ant: If Item 27 lury or other tra		20a. Method of Disposition 1	.lside Road; Cat (Name of r or other place) Iem. Garden 5/2/	Date 200	Location - City or To	own, State
Baltii	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licenses 22. Nam Fit 1630	ne and Address of FacilitySter ineral Home of (Edmondson Aver	ling Ash Catonsvill	ton Schwab Le,Inc.	Witzke
	Frrysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition or equal to the shock of	10 mars 1 mars 24 mars 10	or respiratory arrest,		Approximate Interval Between Onset and Death
3760, <	ate be executed hysiclan and he burial-transit	Ical Examiner	t any hard but it are halfata. Due to for as a consequence of:				
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Med		pic pregnancy ar (specify)		23d. Date of deliv Month	ery Day Year
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underly Ischemic cardiomyopathy	ring cause given in Part I.	23e. Did tobac	co use contribute lo t	he cause of death?
of Vital Records,		Completed	Obstructive sleep aprica		24a. Was an autopsy performed 1 ☐ Yes 2	prior to co	opsy findings available impletion of cause of 227No
Vita	Phyalcian: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 notice 2 ER/Outpatient 3	Other	n <i>(Check only one)</i> me 5 □ Residenc	e 6 Other (Speci	fv)
	g je		27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 2 Accident investigation	28c. Injury at Work?	28d. Describe how		,,
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	Hosp 24 hou Fune letely fill	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigence) and manner stated.	urred at the lime, date and place, lation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as a and place, and due to	stated. to the cause(s)
)	To th Withir To th	Me	29b. Signature and tity of certifier Bichwory M. Pinh	99c. License number		Pril 28,	•
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Bichhuong M. Dinh 900 S. Caton	Ave , Box #60			
-	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 1 2006 32. Registrar's Signature	to the second			

6-02811			lease Type or Pri					
irace P. Stewart		State of M	laryland / Departme			ygiene	2007	1051
Physicia		Registrar 1. Decement's Name (First, Middle, Lest)	Септис	ate of Deat	n	Reg 2. Date of Death	, No. 4 UUL	3. Time of Death
Medical Examir	_	Grace P.	Stewa	R+			Dav Year	1724 hrs
		4a. Facility Name (if not institution, give stree	t and number)	, ,	Town, or Location of Death		4c. County of Deatl	1
	=	University Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birt		nore City er 1 Year If Under 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9. Bii	tholaco (State or
Funeral Director	4	217-50-4960 1 M		Yrs. Month		_	Foreign	
	ŕ	Usual Residence of Decedent		115.		11/-8	·401°	<u> </u>
w any		10a. State 10b. County	10c. City, Town		Dian			10d. Inside City Limits
aryland 8a-f sho	흱	10e, Street and Number	MIC	de l	Code	I 10/	g. Citizen of What Cou	1 Yes 2 No
with the Maryland us 23a or 28a-f show be notified at ARE.	Director	7141 Car Va	Description of the second	0	21220	10		_
S 5 €	_ 1		as Decedent Ever in U.S.		ent of Hispanic Origin? (Sp			ican Indian, 8lack.
hours after death natural", or iten Examiner must I	Funeral	1	Ymed Forces? Yes 2 No		fy Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	LOOK
hours after "natural", Examiner	<u>a</u>	Widowed 4 Divorced If Yes, or Date 15. Decedent's Education (Specify only high	les:	_	No specify: Occupation (Give kind of v	vork done	Specify: 16b. Kind of Business/	Industry
61 3	eted				rking life DO NOT use reti		11	
0036 within 72 giene her than	Completed	124		Nur.	se		Health	Care
. a 8.88 #	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	aiden Surname)	
	8 2	19a. Informant's Name/Relationship (Type, P	rint Daughter 191	b. Mailing Address	S (Street and Number or I	Rural Route Numb	per, City or Town, State	e, Zip Code)
nore, MD 2 ges 1 and 2 shou nt of Health and N r: If item 27 is n other traumatic		eslie Ann Mu	roll o	2141 Co	ckspurl	d, Mid	de River,	MD 21220
ore, sslam of Hea If item		20a Method of Disposition 1 Burial 2 Cremation 3 Re		of Disposition (Nation) or other place		Date	20c. Location - City or	Town, State
P. P. P.		4 Donation 5 Other Specify:	Fard	enosto	140 5	4/06	Balto.	MD
Balt permit. Depart Import injury	l	21 Signature of Funeral Service Licensee	MO1363	28. Jame and	Address of Facility	zare to	ugeral S	ervices
Physician	\dashv	23ar Part I. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death. Do no	ot enter the mode	of dying, such as cardiac of	or respiratory arres	st, shock, or heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a. ath	erosclerotic card			асшів пуре	ertensive	Between Onset and Death
1		or condition resulting in death) Due to	o (or as a consequence of):					
	Je.		o (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to	(or as a consequence of):					
executed an and al - transit	cal Ex	d						
§ 5 5 − 1	dic	X unpended X ame	item#23a,	PII,27,28a	-f,perME,g856,6	/12/06 TT		
Box 68760, e death certificate be er the attending physician ed for use as the burial	n/M	23b. Was decedent pregnant in the	c. If yes, outcome of pregnancy Live birth	Fetal death	3 Ectopic pregna	ancy	23d. Date of deliver Month	y Day Y ear
or use	sicia	past 12 months? 1 Yes 2 No 9 V Unknown	Pregnant at time of death	5 Other (Spe	ecify)			
that the dered by the a	Physician/Medi	Part II. Other significant conditions contr	Unknown	a in the underlying	g cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
es es	d by	Diabetes renal disease	_		3		2 No 3 Pro	
ords,	Completed					24a. Was a		utopsy findings available completion of cause of
Reco The law icate has	dmo					perform	ned? death?	
tal Recian: The certificate	Be C	25. Was case referred to medical examiner?			26 Place of Death (Check	only one)		
F Vit	ို	1 ✓ Yes 2 No		Outpatient 3 []			Residence 6 Othe	er:
n of Inding Ph	ion:	1 Netural	(Month, Day Year)		28c. Injury at Work?		ow injury occurred	
VISIOF or Attend frer death Director: in by the	ficat	2 Accident Investigation	nd 4/ 1/ 2006 Junk 28e. Place of Injury - At home, f		Λ	unk 28f. Location (St	reet and Number or R	ural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:		(Specify) Hospital			Baltimor	e, MD Univers	sity Hospital
To the Hoswithin 24 ho		29a Certifier (Check only one) 2 Medical Examiner:On the	to the best of my knowledge, de					
To the within To the complet	Medical		manner stated		Oc. License number	a. the time, date a	29d. Date signed (Mo	
			10		O.C.M.E.		April 26, 2006	
		30. Name and address of person who compl	eted cause of death (Item 23a)					
				Penn Street,	Baltimore, MD 2120	1 		
St Regis	tate trar	31. Date filed (Month, Day, Year) MAY 0 1 2006	2 Registrar's Signature	borek				
	_							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#21, per FH 9855 5/1/06 TT
Clare of Maryland Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vear **Physician** 10:35 ₽^M April 26, Catherine Elizabeth Snyder 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2823 Harford Road Fallston Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Yrs 212-28-7834 Director 93 17, 1912 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be nutilised at 1 ☐ Yes 2 ☐ No Director Maryland | Harford Fallston 10f. Zin Code 10g Citizen of What Country? 10e Street and Number 2823 Harford Road 21047 or Itams 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 shoutd be filed within 7 h and Mental Hygiene.
7 Is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Burkins, Sr. Charles Melvin Catherine Elizabeth Lagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 Is t 2823 Harford Fd., Fallston, Maryland 21047
Loc of Disposition (Name of Date 200. Location - City or Town, State Phyllis F. Neely / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Bel Air Memorial Grdns. 4-29-06 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 21. Signature of Funeral Service Licensee Stephen A. Hughes (per DVR) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Cancer Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Fig. 1) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit be executed Due to (or as a consequence of): physician a P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown sufficience Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performad? Yes 22 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 27. Manner of Death 1/□Natural 2 □ Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2 To tha tha 29d. Date signed (Monthy Day, Year) 29c. License number 29b. Signature and title of certifier 0 Wall 34208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1718 W Jarrettsville Rd, Jarrettsville MD 21084 WACSH MI) 32. Registrar's Signature 31. Date filed (Month, Day, Year) and I State MAY 0 2005 Registrar

CHAPTINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieñe

	•		1 - For State Registrar	State of Ma	iryiand /	-	ificate of		Mental Hyg	eg. No.	13545
	Physici /Medic		1. Decedent's Name (First, Middle, La	Spin	IAK				2. Date of Deat AMONTH	Day 17 Year 2000	- 10 110 AM
	Examin		4a. Facility Name (If not institution, giv NORTHWEST HOSPIT				4b. City, Town, o		ith	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. S		(In yrs. last i		If Under 1 Year Months Days			9. Bi	rthplace (State or Foreign ountry) RUSSIA
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	ation				10d. Inside City Limits
	a-fah	ctor	MD BAL	TIMORE				OWING	S MILLS		1 ☐ Yes 2 🂢 No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 1032 CAMPBELL ME	ADOW ROAD			10f. Zip Code	21117	1	0g. Citizen of What C	Country? USA
036	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28a-f ahow The Medical Examinar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba □ Yes 2\\ No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	within iene. than *	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	ducation ide completed) College (1-4or 5-	4)	(Give ki life. Do	nt's Usual Occup ind of work done O NOT use retired INICAL EI	during most of wi d)	orking	16b. Kind of Business	
land 2	ould be filed Mental Hygi Markad other Markad other	To Be C	17. Father's Name (First, Middle, Last, KELLMAN			SPIVA	ιK	18. Mother's Na ZLATA	ame (First, Middle, M	,	JCHITEL
	alth and N		19a. Informant's Name/Relationship (-						City or Town, State,	Zip Code) S, MD 21117
Baltimore,	permit. Pages 1 and 2 should be filed Department of Haalh and Mental Hyg Important: If item 27 is marked other any injury or other traumatic evant, any iojury or other traumatic evant,		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif				tion (Name of atory or other place HEBREW (Date 28/2006	20c. Location - City o	r Town, State RSTOWN, MD
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	attle			Name and Addre	J		ON & BROS	
m	Physician	a s	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	Θ.	o not enter	the mode of dyin	ng, such as cardia		est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequenc	e of):					7. 2
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequenc	e of):					
68760,	tificate be executed g physician and as the burial-transit	ledicai Exa	resulting in death) Last	Due to (or as a	onsequenc	e of):					
.O. Box 68	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of the control	2 Fetal dea		ctopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
s, P	es be	by	Part II. Dther significant conditions of	ontributing to death bu	it not resulting	g in the und	derlying cause giv	en in Part I.		pacco use contribute t	o the cause of death?
Record	e law has b	Completed							24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	Magnital:			T 044		eath (Check only on	е)	
of	ding Phys h. After this funeral di	tion: To	1 Yes 2 16 27. Manner of Death 1 Natural 5 Pending 2 Assident investigation	Hospital: 1 patier 28a. Date of Injun (Month, Day	-	Outpatient Time of Injury	28c. Injur Wor	y at		ence 6 Other (Spe ow injury occurred	ecify)
O safegue	of or Attanding after death. Diractor: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		ry - At home, . (Specify)	farm, stree			28f. Location (St. City or Town	reet and Number or F 1. State)	iural Route Number,
	To the Hospital or Attan within 24 hours after deat To the Funaral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner state	examination :	lge, death o and/or inve	occurred at the tinestigation, in my o	pinion, death occ	curred at the time, da	ate and place, and du	e to the cause(s)
•	To the within 2 To the complet	Me	29b. Signature and title of certifier	rather M	P		29c. Licens	e number 4288	25	9d. Date signed (Mon	th, Dex. Year) -7 2006
7	L		30 Name and address of person who	completed cause of de	path (Item 23a	(Typa. B	thet 1	formita((enter		
	Sta Registr		31. Date filed (Month, Day, Year) MAY () 1	32. Rabistra	r's Signature	A	aste)				

ORIGINAL

Thomas, John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#16b, perFH, \$355.5.5/1/06 TT Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 23, 2006 **Physician** Naomi Rosa Thompson 8:23 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2810 Presbury Street Baltimore N/A 5. Social Security Number 212-22-9279 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or F. Country)
April 29, 1917 Maryland 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1 M 2 XF 88 Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits TYTYes 2 □ No MD N/ADirector Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2810 Presbury Street USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2% No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specity: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Emerson College (1-4or 5+) Florenty/Serdan (8:12) Waitress Edmondson Hotel 17. Father's Name (First, Middle, Last)
Isaac Parker 18. Mother's Name (First, Middle, Maiden Sumame) Be Daisy 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3424 Yataruba Drive Baltimore, MD 21207 ^{19a.} Informant's Name/Relationship *(Type, Print)* Janet Smith/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Arbutus Memorial Park4/29/06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee Warres 5240 Reisterstown Rd. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Hypenhumon Due to (or as a consequence of): Arrhyth mias fearing Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a const that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

W

Funeral

Director

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r then "natural", or Items 23a or the Medical Examiner must be r

death

Pages 1 end 2 should be filed within 72 hours after

eith and Mental Hygiene. 27 is marked other then "r ir treumatic event, the Med

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Examiner

/Medical

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After the

Director:

within 24 hours efter de To the Funeral Direct completely filled in by 1

death.

director

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O. I

Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) MAY 0.1

29b. Signature and title of certifie

Thaw Youn



Than POON, md, FARP



29c. License number

D 57088

29d. Date signed (Month, Day, Year)

April 25, 2006

30. Name and address of person who completed cause of death (frem 23a) (Type, Print) #707 Bartimen, MD 21202

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** VENTURE UCILL APRIL 27,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1977 Saint Joseph Medical Center Baltimore 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F SEPT 13, -14-7599 6 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other then "natural", or itame 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Ves 2 □ No To Be Completed by Funeral Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? PKWY APT. 624 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent/Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☼ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+(PHD) BALTOCITY PUBLIC. THERAPIST TEACHER 17. Father's Name (First, Middle, Last) (ロルドルルロル) 18. Mother's Name (First, Middle, Maiden Sumame) ENNIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ASHLEY (COUSIN) 3002 FRANKLIN RMA C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04-29-06 BALTIHORE, MARYLAND BROWN JR. FUNERAL HOME 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 21. Signature of Fur eral Service Licensee TON AVE. 40 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOMYOPATHY YEARS /Medical Due to (or as a consequence of). Examiner CORONARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed neral Director: After this certificete has been signed by the attending physicien end filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 menths? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; within 24 hours efter death. To the Funeral Director: After this certificete 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No М investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HELOU M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) Ire Control State MAY 0 1 2006 Registrar

ORIGINIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrer	State of Maryla	nd / Depa	artment of He	alth and M	ental Hyg	_	13549
Physi /Med Exam	dical	Decedent's Name (First, Middle, Las Aa. Facility Name (If not institution, give 5018 Stone Shop	Doris Ho	ward	Wallace 4b. City, Town, or L Owings Mi			23 2006 4c. County of Death Balto	3. Time of Death 1:30 P. M
Funera Directo		Usual Residence of Decedent	□ M 2★□ F 82	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 7-20	9. Birth -1923	nplace (State or Foreign untry) Md
ith the Marylan or 28a-f show	Director	10a. State 10b. County 10c. Street and Number	to C	ity, Town or Lowings	Mills 10f. Zip Code			log. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No untry?
ges 1 and 2 should be filled within 72 hours after death with the Maryland of Health and Mental Hygiene. The control is a flean 271 and mental Hygiene. On the ma 23a or 28a-f show or other traumatic event, the Medical Event at must be a cultipled at	by Funeral Director	5018 Stone Shop 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 20 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 🕅 No		ecify Yes or No- Rican, etc.)		
led within 72 ho lygiene. har than "natur it, its Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation de completed) College (1-4or 5+) Master Degre	(Give	dent's Usual Occupat b kind of work done du DO NOT use retired) incipal	ring most of worki			ndustry City School
2 should be filed within and Mental Hygiene. Is marked other than raumatic event, its Mental Hygiene.	To Be	17. Father's Name (First, Middle, Last) Jacob DeWitt 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maili		Lillie M	atthews	Maiden Surname) r, City or Town, State, Z	ip Code)
Pages 1 and 2 nent of Health of Health int: If item 27 inty or other tra		Lester B. Walla 20a. Method of Disposition 12 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify	20b. Removal from State	Place of Dispo cemetery, cre rownsv	osition (Name of matory or other place, ille Veter	an 4-28-	2006	te, N.C. 28 20c. Location - City or 1 Crownsvill	Town, State
permit. Pages Department of H Important: If its any injury or of	Succ	21. Signature of Funeral Service Licen 23a. Par 1. Enter th. disease, or comp. sh. k, or heart silure. List only or	SK eke			300 Waba	sh Aven	ue Balto,	Approximate
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To the Hospital within 24 hours: To the Funeral completely filled	Medical	29b. Signature and title of certifier	iner: On the basis of examinand manner stated.		29c. License	number	- 2	29d. Date signed (Month	n, Day, Year)
	State	30. Name and address of person who declared the state of	completed cause of death (Ite 1971- 32. Registrar's Sign	2 / / (¢	Print) Mary 1	and Sia	Bo	April 12	2146
Regis	strar _š	11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0000	H. B	08442				

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician 5:25а м Maria Grace Whitmore April 28,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrest Towson
If Under 1 Year | If Under 24 Hrs. | Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Days Hours Min 1 □ M 2 🔀 F 38 220-72-2672 Yrs Director Baltimore, MD 6-7-1967 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 Ia marked othar than "natural", or Itams 23a or 28a-f ahow traumatic avant, the Medical Examinar must be notified at MD 1 Yes 2 No Director Arbutus 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Piedmont Court 21227 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2√2 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Dr. Hesson College (1-4or 5+) Elementary/Secondary (0-12) Medical Secretary Dr. Hammond 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fi Health and Mental h Gino Polsinelli Geraldine Sitar 19a. Informant's Name/Relationship *(Type, Print)* husband 📗 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* Department of Health a Important: If itam 27 is any injury or other trains0000. 8 Piedmont Ct. Arbutus, Christopher A. Whitmore MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/2/2006 Baltimore, MD Meadowridge 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Joseph N. ZanninoJr.FH 21. Signature of Funeral Service Licensee arus 263 S. Conkling St.Baltimore, MD 21224 23a. Part1. Enter the disease, or con shock, or heart failure. List boy plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physicien and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐ Unknown certificate has been signed by ector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 \(\text{No}\) To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) HOSPUE 1 Tyes 20,No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending death. 1 TYes 2 TNo 2 Accident investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Broot, MD/6601 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

ORIGINAL

			1 - For State Registrer	State of Maryland	/ Departmer	nt of Health and te of Death	•	2 006	3551
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	Funeral Director		5. Social Security Number 3. 50 5403 Usual Residence of Decedent	Sex 7. Age (In yrs. last 55	st birthday) If Unde Months	or 1 Year If Under 24 Hr Days Hours Mir	s. 8. Date of Birth	9. Birthpla Counti	ace (State or Foreign ry)
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Baltimore,	permit. Pages Department of I Importent: If it any injury or o		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	(y) M+	Zion Cem	nd Address of Facility	3/06 La	NSdowne	Md
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	7		30. Name and address of person who FALU UMA	210 RUMNE	(3a) (Type, Print)	ER DRIVE	REISTERSTO	wn mo	21136
4	Sta Registr	te ar	31. Date filed (Month, Day, Year) MAY 0 1 2001	32. Registrar's Signatur	A STATE OF THE PARTY OF THE PAR				

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death April 23, 2006 **Physician** Mary Ann Yockey 9:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🔀 F 408-22-8691 82 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28s-1 ehow amy injury or other treumatic event, the Madical Examinar must be politised at ODEs. 1 ☐ Yes 2 ➡ No Maryland Harford Bel Air Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1507 Balmoral Drive 21014 **USA** Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Wesley Leach Laura (unk) Parton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pr. Hubert P. Yockey/husband 1507 Balmoral Drive, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-26-06 Bel Air, Maryland Thomas Run U.M. Cem. 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Figneral Service Licensee 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 No To the Funeral Director: After this certific bompletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSpice 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after o determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 Dulaney Mahmood, MD Year) 32. Registrar's Signature 31. Date filed (Month) Day, Year) State MAY 0 1 2006 Registrar

		,	1 - For State Registrar	State of Ma	-		nt of H	ealth a		ental Hy	giene Reg. No.	06	1355	3
et,	Dhysiai	an	1. Decedent's Name (First, Middle, Las						2	2. Date of Dea Month	Day	Year	3. Time of D	
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			For State Registrar	State of Maryland		artment of H tificate of L			giene	6	13554
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36	within 72 hours after death with the Maryland one. then "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married **Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		ce - Americ ck, White, ^{y:} Bla	etc.
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	and 2 shousalth and Market 127 is mailer treumal		19a. Informant's Name/Relationship (Typ. Quentin Shawn A	ddison 9	24 10	g Address <i>(Street a</i> Oth St 1	NE, Was				
Baltimore,	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show eny injury or other treumatic event. The Medical Examinar must be notified at once.		20a. Method of Disposition X Burial 2 □ Cremation 3 □ R: 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lions	Squa	are 1	sition (Name of natory or other place Deal Cer	netery	Di Mi	ishop	ville	
	Physician		23a. Part1. Enter the disease, of complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. e cause on each line.	V	er the mode of dyin	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
1	/Medical Examiner	<u>.</u>	Sequentially list conditions.	Due to (or as a consequer	nce of):						
- 09	that the death certificate be executed ad by the attending physician and detached for use as the burial-transit	al Examiner	if any, leading to a minerate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer							
x 68760,	entificate ding physise as the I	/Medical	IF FEMALE:	Bc. If yes, outcome of pregnance							
P.O. Box	The law requires that the death certif ate has been signad by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)				te of delive onth	ery Day Year
	w requires that been signad t should be det	by	Part II. Other significant conditions con	tributing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.				he cause of death?
al Records,	ding Physicien: The law n h. After this certificate has be funeral director, page 2 sh	Completed						24a. Was autop perfor 1 \sum Yes	sy med2	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 22 No
fVit	ysicier is certif directo	To Be	25. Was case referred to medical examiner? 1 Z Yes 2 No	ospitał: 1 □ Inpatient 2 ⁄ EP	VOutpatien	t 3 DOA Othe		eath (Check only on Home 5 Resid		ıer (Specit	(y)
Division of Vital	anding Ptath. Tath. Tater the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury	Work	rat ⟨? Yes 2 □ No	28d. Describe h	ow injury occur	red	
Divis	ital or Attenders after deatles after deatles after deatles after deatles after afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				City or Tow	m, State)		al Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Diractor: After this certified completely filled in by the funeral director, I	Medicai	(Check only 2 Medical Examir	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inv	vestigation, in my or	oinion, death oc	curred at the time, o	date and place,	and due to	o the cause(s)
	T wit	-	29b Signature and title of certifier	~ MD		29c. License	319		29d. Date signe		
ر _	(3)		30. Name and address of person who co	AMMER		ROCK	Ville.	rd Br.	# 202	208	350
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 1 2006	2. Registrar's Signatur	Some	E)					

			1 - For State Registrar	State of Ma		-	ment of Ficate of				Reg. No.	6 1	3555
	Physici		Decedent's Name (First, Middle, Last) Johnny Marvin							2. Date of De	Day	Year 2006	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give Upper Chesapeake	street and number)	Center		o. City, Town, c Bel Air			- gore	4c. Count	ty of Death	
	Funeral Director		420-32-4301	7. Age	(In yrs. last birt		Under 1 Year onths Days	If Unde Hours	Min.	8. Date of Birt (Month, Pa Jan • 7,	^h . 1945	9. Birthpi Coun Tenne	lace (State or Foreign try) SSEE
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location	on					10	0d. Inside City Limits
	Be-feb	ctor	MD Harford		Ab	ingdo	on						1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23a or 28e-f ehow rmust be notified at	Dire	10e. Street and Number 2943 Raking Leaf I	rive		1	Of. Zip Code 21	009			10g. Citizen of U.S.		try?
m Se	5 £ 5	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:			Decedent of H s, specify Cub Yes 2🔯 No			cify Yes or No Rican, etc.)		ce - Americack, White,	etc.
8:12-PM	ofthin 72 hounder.	Completed I	15. Decedent's Edu (Specify only highest grade	cation	b)	(Give kınd life. DO l	's Usual Occup of work done NOT use retire Lte Enq	during mo d)		ng	16b. Kind of E	3usiness/înd	dustry
Do 200	latte filed w lental Hygie rked other til	To Be Co	17. Father's Name (First, Middle, Last) Jonathan Atnip	ЭŦ		acer	re mg	18. Moth	ner's Name	(First, Middle, Isabel			
20	d 2 shouth and N		19a. Informant's Name/Relationship (Ty Deborah Elliott (S				ddress (Street			Abingdo		n, State, Zip 21009	
8 20/0c/	ages 1 an of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3	emoval from State	20b. Place of cemeter	Dispositio y, cremato		се)		ate	20c. Location West Ch	- City or To	wn, State
4/2	permit. P Depertme Importan eny injury		4 □ Donation 5 □ Other (Specify) 21. Signature → Funeral Service License	300	R. A.	rerr. Tai	me and Addre	ss of Facil argo	Funei	ral Hom 21001	e, P.A.	lescer	, th
•	Physician /Medical		23a. Part 1. Enter the disease, or cooking shock, or heart failure. List only or immediate Cause (Finaf disease or condition resulting in death)	Orterio	the death. Do not be.	lic enter the	e mode of dyir	ng, such as	s cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
5249	certificate be executed and inding physicien and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):							
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10 1	Physician: The labilities the ral director, page	Be	25. Was case referred to medical examiner?	ospitaf:	Neno		Oth	OF.		Check only or			,
7	sing Ph	tion: To	27. Manuer of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. T	ime of	28c. Injur	4 🗆 14	2	ne 5 Resid)
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A	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)	sician: To the best of ter. On the basis of and manner stat	examination and	, death occurrences	curred at the tir gation, in my o	me, date a pinion, de	nd place, a ath occurre	and due to the ded at the time, d	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Ha Illi	In MIN	AM	29c. Licens	e number	1471		29d. Date signe	ed (Month, E	Day, Year)
	5x1		30. Name and address of person you co	YUKE	ath (Item 23a (Type, Prin	7018	HOL	11) Ro	1 Ave	BALTO	MIG	21223
	Sta Registr		31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) MAY 0 1 2006	32. Registra	r's Signature	alles							

			1 - State Amend#23a, 4	State of Mary	land/Depart Dr., H	artment o	of Health a	and Me	ental Hy	giene	13556
			1. Decedent's Name (First, Middle, Last						2. Date of De Month		3. Time of Death
	Physici /Medio		Julio C. Alvarez							16, 2006	11:48 P ^M
7	Examir	er	4a. Facility Name (If not institution, give				m, or Location of	of Death		4c. County of Dea	
			18023 Snow Creek 5. Social Security Number 6. Se		tion to at birth days	Gaithe If Under 1 Y	rsburg	24 Hrs	9. Date of Did	Montgome	
	Funeral Director			M 2□F	yrs. last birthday) 80 Yrs.	Months Da		Min.	8. Date of Bin (Month, Da Mar 25	y, Year) 1926 Nic	inthplace (State or Foreign Sountry) Caragua
	yland		10a. State 10b. County	10	c. City, Town or Lo	ocation		-			10d. Inside City Limits
	8a-f	cto	Maryland Montgome	ry G	aithersb	urg					1 ☐ Yes 2Ã No
	ith th	Dire	10e. Street and Number			10f. Zip Coo				10g. Citizen of What C	Country?
	e 23e	eral	18023 Snow Creek		in II C 12	20877		:=i=2 /C==	du Van as Na	USA	andrea Indian
98	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow other traumatic event, the Medical Examiner must be coullised at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 【X Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify (of Hispanic Ori Cuban, Mexicar No Specify:			14. Race · Am Black, Wh	
8	urel',	q p	3 Widowed 4 Divorced	Year or Dates:	140-0	4. 4. 11. 10		Nica	caguan	H1	spanic
7	in 72	olete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Oo kind of work do DO NOT use re	one during mos.	t of workin	g	16b. Kind of Business	s/Industry
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<u>la</u>	Mente Mente arked	To E				(unk)	Juan	na Cru	1Z		
Maryland 21215-0036	d 2 sho h and 7 is mu traum		19a. Informant's Name/Relationship (7) Maria A. Bonilla/			_				er, City or Town, State, Potomac, MD	
ē,	1 and Healt Iem 2		20a. Method of Disposition		Ob. Place of Dispo	sition (Name o		Apri		20c. Location - City o	
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 any Injury or other once.		1 ☐ Burial 2 【YCremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		Chesapea	matory or other ke Crem		200		Beltsville	
Ball	Deperition Deperition Deperition Deperition Depertment of the Brown Inc.		21. Signature of Funeral Service Liceris	1-11-						ice P.O. B	Sox 784 1e, MD 21029
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	Physician		Immediate Cause (Final disease or condition	.Pancreatic	Cancer						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co							months
	_xammor	16	Sequentially list conditions,	Due to (or as a co	risa wenne of c						
	nsit	nlne	Cause (Disease or injury	20013 (0: 35 4 0)	insoquence ory						
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Division of	p # 2 =	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, off	ice	21	Bf. Location (S City or Tox	Street and Number or R	Rural Route Number,
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	To the within 2 To the complet	Med	29b. Signature and title of certifie	and manner stated.			cense number			29d. Date signed (Mon	
	F 3 F 8		17/W/V	~~~		D29	675]	April 17, 2	
8	102	. 39	30. Name and address of person who o			Print)	-			•	
7			Ralph V. Boccia,			e Drive	Suite	4100	Bethes	sda, MD 208	51/
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 8 20	32. Figistrar's !	Signature	and -					
011	MU 17 Day 1/0	204			150						

			For State Registrar	State of Maryland /	-	tment of H			iene	16	135	57
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h		3. Time of	Death
	Physici /Medic		RALPH LEE BARNES					Month April	Day 12. 200	Year 06	9:35	а м
*	Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or	Location of Death			ty of Death		
			Holy Cross Hospit	al		Silver			Mont	gomery	Z.	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	Cour		-
	Director		578-56-9753 Usual Residence of Decedent	63	Yrs.			March 4,	1943	Wash	ington	DC_
	and ow		10a. State 10b. County	10c. City, Tox	wn or Loca	ation				1	0d. Inside Ci	ty Limits
	Mary 1 sh	ţ	Maryland Prince Ge	orge's Green	halt						1 ∑Yes	2 🗌 No
	r 28a	Director	10e. Street and Number	orge o dreem	DCIC	10f. Zip Code		1	0g. Citizen of	f What Cour	ntry?	
	deeth with the Maryland tms 23a or 28a-f show ir must be notified at		73-E Ridge Road			20770			U.S.A			
	deet	Funerai		Was Decedent Ever in U.S. Armed Forces?	13. W		spanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Ra	ace - Americ		
و	or its		1 ☐ Never Married 2 X Married	1 ☐ Yes 2 📉 No If Yes, Give		Yes 2⊠ No	Specify:	o rican, etc.)		ack, White,		
Maryland 21215-0036	be filed within 72 hours efter deeth with the Marylan de Hygiene. de Hygiene. de thy then "naturel", or items 23a or 28a-f show other then "naturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			эрвену.		Spec	whi	.te 	
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N D	Hygie ther ther	ပိ	17. Father's Name (First, Middle, Last)	4 E	ngine	eer	18 Mother's Nar	ne (First, Middle, M			n Works	s, me
an	Aental Irked o) Be								,,,,,		
2	should ind Meni	ဥ	Ralph T. Barnes 19a. Informant's Name/Relationship (Typ	ne. Print) 19	b. Mailing	Address (Street a		rie <u>Harri</u> Iral Route Number		n State Zin	Code)	
	and 2 sealth ar n 27 is		Vera K. Barnes -			·				,,		
Baltimore,	Heg Heg the		20a. Method of Disposition	20b. Place	of Disposit	tion (Name of		belt, Ma	20c. Location			
Ē	000====		1 🖾 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movai from State	-	itory or other place. In Cemete:	1	8/2006	D	1		
<u>=</u>	it orts	1	21. Sign ture Funeral Service License		22.	Name and Addres	s of Facility G	asch's Fu	peral	Mome.	Maryla D A	ind
Ö	Dep Pen		Petrin Truto	5 MO1343	5 47	'39 Balti	imore Ave	e., Hyatt	sville	MD .	20781	
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	/Medical		resulting in death)	Due to (or as a consequence		LILUTE						
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	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					224 D	ate of delive	200	
Вох	death atter	ciar	in the past 12 months?	1 Live birth 2 ☐ Fetal deat 4 Pregnant at time of death		ctopic pregnancy Other (specify)				fonth		r'ear
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Ē	ding P h. After t funera	i o	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	28c. Injury Work		28d. Describe ho	w injury occu	irred		
Division of	tend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No					
\leq	N or Att after d Direct d in by t	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (St. City or Town		iber or Hura	il Route Num	ber,
	Hospital or 24 hours after s Funeral Directory filled in		29a. Certifier 1(X) Certifying Physi	ician: To the best of my knowledg	ne death	accurred at the tim	ne date and place	and due to the co	use/s) and n	nagnor ac c	lated	
	24 h 24 h Fur etely	Medical	(Check only 2 Medical Examin one)	er: On the basis of examination a and manner stated.	ind/or inve	estigation, in my or	oinion, death occu	rred at the time, da	ate and place	, and due to	the cause(s)
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	Me	29b. Signature and title of certifier			29c. License	number	25	9d. Date sign	ed (Month,	Day, Year)	
	(2)		> Kshaw	e ciarl		D608	26		April	12, 20	006	
	(0/0		30. Name and address of person who con	mpleted cause of death (I em 23a) (Type, P	rint)						
	3C		Kshama Garg, MD	Holy Cross Hosp	oital	, Silver	Spring	Marylan	d			
	Sta		31. Date filed (Month, Day, Year) APR 1 4 2006	32. Rebistrar's Streetur	1		1					
	Registr	ar	WINTE GOOD		•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** APRIL 4:00 A M 2006 James Elber Brooks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHING TON MEDICAL CENTER
5. Social Security Number | 6. Sex | 17. Age (In yrs. last birthot BURNIE ARUNDEL ANNE GLEN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1☐M 2□F Yrs. Director 228-42-5920 68 Feb. NC Usual Residence of Decedent the Maryland 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits other then "netural", or items 23a or 28e-f showent, its Modical Examiner must be notified at 1 Nes 2 No Directo MD Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 7466 Furnace Branch Apt. 404 21060 by Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Correctional Officer $_{
m GED}$ traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked ၉ Esau Brooks, Sr. <u>Lissie Ann Bowser</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 0 0 9 3 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Depertment of Health ar Important: If Item 27 ie eny injury or other traugnos. Charles E. Brooks- Brother 1100 Indian Trail Rd., #1926, Norcross, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oakwood Cemetery 4-11-06 Richmond, VA 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death **Physician** /Medical Examiner CARDIOMYOPANIY Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physicien end to be detached for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4. Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has rector, page 2: 1 Yes Division of Vital 201No : After this certifications a funaral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) | Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Matural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident i Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerei Di completely filled in 1 A Certifying Physician: To the best of my knowledge, death oppored at the time, date and class and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

3

29b. Signature and title of certifier

morte

APR 1 4 2006

SALA

JAMES

Shoks

DHMH 17 Rev 1/2001

WOSPINAZ

29c. License number

CHAR

29d. Date signed (Month, Day, Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1) Sui Now

32. Registrar's Signature

		1	For State Registrar	S	state c	of Maryla	ind / Dep <i>Ce</i>	artmen rtificat					Rag. No.	00	6	13559
		_	Decedent's Name (First, Middle									2. Date of Do Month	Day		Year	3. Time of Death
	Physicia /Medic		THOMAS BROO	KS								APRIL	10	200		5:50 A M
	Examin		4a. Facility Name (If not institution	-		mber)				Location of SPR				County o MONT		
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	Funeral		5. Social Security Number	6. Sex 1 ☑ M	2 🗆 F	7. Age (in yr	rs. last birthday Yrs.	Months		Hours	Min.	(Month, D	ay, Year)		Cou	GINIA
	Director		218-32-7782 Usual Residence of Decedent			70						AUG. I) 193		VIV	GINIA
puel	A I		10a. State 10b. County			10c. (City, Town or L	ocation								10d. Inside City Limits
N Cal		ţō	MD PRINCE	E GEO	RGE '	s I	LARGO									1 ☑ Yes 2 ☐ No
t d	128	lrec	10e. Street and Number					10f. Zip						zen of W		intry?
3	23a c	Funeral Director	10704 MT. LUB	ENTIA	A WAY				0772					J.S. <i>F</i>		
9	8 E	ner	11. Marital Status	12.	Was Dec Armed F	edent Ever in orces?	U.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Or n, Mexicai	rigin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-		- Amer , White	ican Indian, , etc.
9	o a la		1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied	1 ☐ Yes If Yes, G Year or I	2⊠No ive		1 🗆 Yes	2 X No	Specify:	:			Specify:		BLACK
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ING Z 1Z 13-0036	othe othe	BeC	17. Father's Name (First, Middle,									First, Middle)	
/land	Menta Menta rrked rtice	2	ALPHONSO D. BR	OOKS							LIAN		ORDO			
lary S	and and series		19a. Informant's Name/Relations				19b. Mai	ling Addres 4 MT.	s (Street a	and Numb ΣΝΤΤΤΔ	erorRur . TJAƳ	al Route Num. LARG(ip Code) 20772
2 €	end leelth m 27 her tr	1	MARGARET BROO)KS/W	1FE	201	D. Place of Disp			214 1 117		Date				Town, State
0	ges t of H if Ite or ot	9	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		noval from	State	cemetery, cri	ematory or	other plac	1						
Baitimo	r. Pa ntmen rtent: njury		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service			(CHURCH	CEMETI 22. Name a				/2006				AL HOME
ת מ	permit. Pages 1 end 2 should be lings within 7.2 hours after death with the way year Department of Heelin and Mental Hygiene. Importent: If them 21 is marked other then "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be multiled at once.		X.D.M		La	ll		7474	LAND	OVER	ROAD	LANDO	VER,M			20785
Ü			23a. Part1. Enter the disease, or shock, or heart failure. List	complica only one	tions that cause on	caused the de each line.	eath. Do not e	nter the mo	de of dyin	g, such as	s cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)			(or as a cons		EOD AT	TON							
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X R O	death certificat e attending phy od for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	230		utcome of pre		□Ectopic p	regnancy	,				23d. Date Mon		very Day Year
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ō	Physic this stal di	; To	27. Manner of Death	-		e of Injury onth, Day Yea		of	28c. Injui Woi		tursing in	28d. Describ				297
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	To the Hospital or Att. within 24 hours after de To the Funeral Direct completaly filled in by ti	edical	29a. Certifier 1 X Certifyi (Check only 2 Madica	ng Physic I Examina	er: On the	he best of my basis of exan anner stated.	knowledge, de mination and/or	ath occurre investigation	d at the til n, in my o	me, date a opinion, de	and place, eath occur	and due to the rred at the tim	ne cause(s e, date an) and ma d place, a	nner as and due	stated. to the cause(s)
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	(10)		1 /100	ill	1				D32	2247			APR	IL	12,	2006
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	St Regist	ate trar	31. Date filed (Month, Day, Year APR 1 4 2006	Black	32.	. Registrar's S	indeature .									

			1 - For State Registrar	State of Maryla		artment of F			iene g. No. 006	13560
			1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medic		BERNICE		ROOKS			APRIL	9 2000	7943AM
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Death	
			DOCTOR'S HOSPITA 5. Social Security Number 6. Se.		. last birthday)	LANHAM If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	PRINCE C	
	Funeral Director		-	M 2127 56	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Co. 24 1949 MAR	nplace (State or Foreign untry) VI AND
	D >		Usual Residence of Decedent 10a. State 10b. County						27 2778 1411	
7	shoved and a	Į.			city, Town or Lo	cation				10d. Inside City Limits 1 Yes 2 No
7	n the Marylan r 28a-f show	Funeral Director	MD PRINCE G	FORGE'S B	OWIE	10f. Zip Code		11	0g. Citizen of What Cou	**
-	23a or	10	4906 COLLINGTON R	OAD		20715			U.S.A.	andy:
7	ter death items 2	nera		12. Was Decedent Ever in L Armed Forces?	J.S. 13.		Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
Q 9	or ite	y Fu	1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 Tes, specify Cuba 1 ☐ Yes 2 ☑ No		Hican, etc.)	Black, White	, etc. BLACK
000	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Mudical Examiner must be motified at	ed by	3 Widowed 4 Divorced	Year or Dates:						
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Mar		ı ij	19a. Informant's Name/Relationship (Ty						City or Town, State, Zi	
e C	1 an 16al 16al		MELVIN B. BROOKS/ 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	ND ROAD GI		YIARY LAND 2 20c. Location - City or T	.0769
Ø ro r	Pages nent of int: If it iry or o		1 Burial 2 □ Cremation 3 □ F Donation 5 □ Other (Specify)	emoval from State	cemetery, cren	natory or other plac CTION CEM	ce)		CLINTON, MA	
	교 돈 돈 곧 .		21. Signature of Funeral Service Licens			. Name and Addre			KINS FUNERA	
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			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ne cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Arteroosch	levote	c Hyper	rtensina	e Hear	t Diseas	Onset and Death
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Вох	attend for us	sian/	in the past 12 months?	3c. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of €	al death 3	Ectopic pregnancy Other (specify)	1		23d. Date of delive Month	ery Day Year
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σ. σ.	res that igned b be deta	by Physician/Med	Part II. Other significant conditions cor	tributing to death but not re-	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records,	w require been sig should b							1 🗆 Ye	s 2□No 3□Pro	bably 4. Unknown
900	as be	Completed						24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
<u>=</u>	The Tate has page	Con						perform	ned? death?	
Vita	yslcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:		1.04	26. Place of Death	Check only one		
ot	Phys this ral dir	ဥ	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 □	ER/Outpatien		4 Nursing Ho		nce 6 Other (Speci	fy)
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visi	Attendi	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ற்றுe, farm, stre			28f. Location (Str	eet and Number or Rur	al Route Number,
Ō	s afte	Certification:	4 Homicide determined	building, etc. (Speci	ny)			City or Town,	, State)	
	To the Hospital or Atterview of the Hours after de To the Funeral Directo completely filled in by the	cai	29a. Certifier 1 Certifying Phys	ician: To the best of my knier: On the basis of examina	owledge, death	occurred at the time	ne, date and place, a	and due to the ca	Use(s) and manner as s	stated.
	the h	Medicai	one)	and manner stated.						
	F \$ F 8		29b. Signature and title of certifier	11-0100	2	29c. Licensi		29	d. Date signed (Month,	Day, Tear)
	14/	,	30. Name and address of person who co	mpleted cause of death //to-	m 23a) /Tuna 1	Print)	05590	4/	The It	1006
	-36	_	Stylon	Ter 3001	HOSP	tel Dr.	ive Cl	verl	Marslan	d
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1	Registra	ar	APR 1 4 2006	we to be						

			1 - For State Registrar 1. Decedent's Name (First, Middle, La.)	State of I	Marylan			of Health of Death	1		Reg. No.	006	1 3 5 6 2
	Physici /Medio Examir	al	Doris Regina Bu. 4a. Facility Name (If not institution, give	llock	er)		4b. City, Too	wn, or Location	j	Manth /	Pay	2006 County of Dea	9:46 PM
	Funeral Director	3 y.	Doctor's Community 5. Social Security Number 160-32-4869			last birthday) Yrs.	Lani If Under 1 Y Months D		r 24 Hrs. 8	Date of Birtl (Month, Day	h v, Year)		thpiace (State or Foreign ountry)
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	eorges	10c. Cit	y, Town or Lo	ocation			00703	,, 15,		10d. Inside City Limits 1 ☐ Yes 2 No
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any Injury or other treumatic event, the Mudical Examiner must be notified at ance.	d by Funeral Director	10e. Street and Number 11000 Lake Arbor 1 11. Marital Status **TMNever Married 2 Married 3 Widowed 4 Divorced	May 12. Was Decede Armed Force 1 [] Yes 29 If Yes, Give Year or Date	ent Ever in U as? ☑Mo	.S. 13.	Was Decedent If Yes, specify	0721 t of Hispanic O Cuban, Mexica KNo Specify			U	S.A. 14. Race - Am. Black, Whi	erican Indian, te, etc. .ck
Maryland 21215-0036	id within 72 h giene. er then "net	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual O kind of work of DO NOT use r sh Teac	lone during mo etired)	st of working			nd of Business	s/Industry
ryland	nould be file d Mental Hy narkad oth natic event	To Be (17. Father's Name (First, Middle, Last) James Bullock 19a. Informant's Name/Relationship (10h Maili	on Addross /S	Vi	ctoria	First, Middle, Fulle	r	Sumame) r Town, State,	Tin Code)
Baltimore, Mai	Pages 1 and 2 sl tment of Health an tent: # Item 27 is r jury or other treur		Phyllis Williams—: 20a. Method of Disposition 1 Burial	Removal from Sta	110	11000 Place of Disposemetery, creater Linc	Lake And continued of the color	Arbor W	ay Bow Dat 04/13	vie, MD	20c. Lo Bren	721 cation - City or	Town, State
Ball	Depart Import any In		21. Signature of Funeral Service Licer	ple	sed the deat	34	01 B1ac		g Rd.	brentw	ood,	F.H. , MD 20	722 Approximate
	Physician /Medical Examiner bhysician and bhysician and the print	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respin Due to (or b. End St Due to (or c. Sanord	natory as a consequence age R as a consequence	Failu (uence of): enal diuence of):	re						interval Between Onset and Death 6 Hours 12 Yrs
, P.O. Box 68760,	Physician: The law requires that the death certificate be executed in scentificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 253No 9 Unknown	d. 23c. If yes, outcomed to the second of t	n 2 ∏ Feta t at time of d n	Il death 3[leath 5[⊒Ectopic pregr □ Other (special	(y)	1.	23e. Did to		23d. Date of de Month se contribute t	livery Day Year o the cause of death?
Records,	The law require ite has been sig age 2 should b	Completed b								1 ☐ Y 24a. Was a autop perfor 1 ☐ Yes	an sy med?	24b. Were a	robably 4 Unknown utopsy findings available completion of cause of
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Division	itel or Attenurs after deat rei Director: lled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building,	, etc. (Specii	(y) 	reet, factory, of			City or Tow	n, State,)	iural Route Number,
	To the Hospitel or Attent within 24 hours after death 1 to the Funerel Director:	Medical	29a. Certifier 1 ⊠ Certifying Pt (Check only one) 2 ☐ Medical Exar one) 29b. Signature and title of certifier	nysician: To the be niner: On the basi and manner	s of examina	owledge, deat ation and/or in	vestigation, in	my opinion, de icense number	ath occurred	at the time, o	date and	and manner a place, and du e signed (Mon	e to the cause(s)
	3/		30. Name and addless of person who				Print)	2752		6	4	1100	6
	Sta Regist		Kadie Leach, M.D. 31. Date filed (Month, Day, Year) APR 1 3 2	32. 9 eg	istrar's Signa	s Rd.		uam, M	J 2070	0			

			For State Registrar	State of Ma			rtment of Hea cificate of De			giene Reg. Ño.	06	13563
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea			3. Time of Death
	Physici		Edith E	Clorence		P	Becker		Month O4	12	2006	6:35 AM
١	/Medic		4a. Facility Name (If not institution, give s			Ť	4b. City, Town, or Lo	cation of Death			ounty of Death	
1	Examin	er								D.	. 1 +	
	- Francisco	-	Mariner Nursing F 5. Social Security Number 6. Sex	10ME 7. Age	(In yrs. last birthda	(V)	Catonsvil		B. Date of Birt	h	altimor	elace (State or Foreign htry)
	Funeral Director			M 217F	90 Yrs.		Months Days H	Hours Min.	(Month, Da	y, Year) 4 191		
			Usual Residence of Decedent		_90				05 0	4 191	J	cyland
	land		10a. State 10b. County		10c. City, Town or i	Loc	ation				1	Od. Inside City Limits
	Mary	to	MD Baltimor	e l	Woodlawn							1 ☐ Yes 2 ☑ No
	28a	Director	10e. Street and Number	_		_	10f. Zip Code			10g. Citize	n of What Coun	ntry?
	within 72 hours after death with the Maryland ene. then 'natural', or items 23e or 28e-f ehow he Moulcal Execulter mat be notified at	ā	7602 Clays Lane Ap	ot 320			2124	44			USA	
	ns 2	Funerai	11. Marital Status	2. Was Decedent E	ver in U.S. 13	3. W	/as Decedent of Hispa	anic Origin? (Spec	ify Yes or No	- 14.	Race - Americ	can Indian,
	ter of their	를	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 N		lf	Yes, specify Cuban, N	Mexican, Puerto R	ican, etc.)		Black, White,	etc.
336	irs a	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2∏ No S	Specify:		Sį	pecify:	White
21215-0036	thor.	ed	15. Decedent's Educ		16a. Dec	cede	ent's Usual Occupatio	n		16b. Kind	of Business/Inc	dustry
15	be filed within 72 hc tal Hygiene. d other then *natu event, It's M. alcal	Completed	(Specify only highest grade		life	ve k	ind of work done duri O NOT use retired)	ing most of working	9			
72	filed withi Hygiene. other than	E	Elementary/Secondary (0-12)	College (1-4or 5- 2 years		em	aker			Н	ousehol	d
9	filed Hygid Sther		17. Father's Name (First, Middle, Last)		122			. Mother's Name	First, Middle,			4
an		To Be	Phillip Acke	erman				Florence	Cros	hone		
<u></u>	2 should and Men is marka aumatic	-	19a. Informant's Name/Relationship (Typ		19b. Ma	iling	Address (Street and				own, State, Zip	(Code)
Maryland	01 (0 .0)				DOA 330	D	C	. Thenber	Lange de la cons	M	01150	
0	s 1 and 2 if Health item 27 other tre		Rev. Harold Britti 20a. Method of Disposition	ngnam -	20b. Place of Disi	DOS	ition (Name of	L, Westun	te to	20c. Loca	tion - City or To	own, State
<u>ē</u>	Pages nent of I ant: If its ury or o		1 ⊠ Burial 2 □ Cremation 3 □ Re	emoval from State	1		atory or other place)		7 0005			
Baltimore,	it. Purtme		'4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Louden	Pa	rk Cemeter	ry: 04 1	2006	Balt	imore	
Ba	permit. Pages Department of Important: If it any injury or o		21. Signature of Furnishing			B	Name and Address ourrier-Que	een Funer	al Hon	ne & (Cremato	cy
	110-24		23a. Part1. Enter the disease, or complic	cations that caused	the death. Do not e	1	212 West (Old Liber	ty Roa	ad, Wi	infield	MD 21784 Approximate
		.	shock, or heart failure. List only on	e cause on each lin	θ.							Interval Between Onset and Death
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	/Medical Examiner		rosoning in death,	Due to (or as a	a consequence of):							
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	ad sit	iner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cue to (or say	Court meruphannaic (cry).							
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87	cate l	edical	d									
_		Me	IF FEMALE:	2. 16	4						-	-
Вох	leath certifii attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth	2 Fetal death 3		Ectopic pregnancy			230	d. Date of delive Month	ory Day Year
	Physicien: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of death 5	5 🗀	Other (specify)					
P.0	d by	Ph)	Part II. Other significant conditions con	tributing to dooth by	it not requilting in the		darbing agus gwas i	in Dart I	23a Did to	phaceo uso	contribute to th	ne cause of death?
	res tha igned l	by	Parkinson's D		it not resulting in the	a um	derlying cause giver i	mranti.				pably 4 Tunknown
ord	w require been sk should b	ted	raryinson 3 17	136636					101	105 2 1	NO 3 FIOD	abiy 4 (Serikilowii
Vital Records,	law las b	Completed							24a. Was	osy	prior to cor	psy findings available mpletion of cause of
<u> </u>	The law cate has)OII							perfo	rmed? 2 ₽ No	death?	2 No
ita	icien: Th certificate ector. pag	Be	25. Was case referred to medical				26	6. Place of Death	Check only o	ne)		
>	ysic is ca direc	70 1	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatie	nt 2 ER/Outpati	ient	3□ DOA Other:	4 Nursing Hom	e 5 🗆 Resid	dence 6	Other (Specify	y)
οľ	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time		28c. Injury at Work?	28	3d. Describe h	now injury o	occurred	
0	ath. r: Af	atic	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,		s 2 □ No				
Division	Atte	iit	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, :	stre	et, factory, office	21	If. Location (5 City or Tox		Vum <i>ber</i> or Rura	al Route Number,
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	To the Hospital within 24 hours a To the Funeral I completely filled						occurred at the time,					
	he H	Medical	(Check only 2 Medical Examir one)	and manner sta	ted.	ILIA	estigation, in my opini	OII, GBAIII OCCUITO	Jac trie tillie,	uate and pi	ace, and due to	(III Cause(s)
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Σ	29b. Signature and title of certifier) (29c. License nu				signed (Month,	
•			rain f. 1	Jalett,	M. D.		1005	58676		Apri	114,	2006
	MZr		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Typ	oe, F	Print)					
	9		waren L. Bavit.	I, MID.	25 Main	2	weet, s.	41 to 201	2 Hi	sters	town, 1	1021136
	Sta	ite	31. Date filed (Month, Day, Year)	32. Resistra	r's Signature							
	Registi	ar	30. Name and address of person who co NOVER L. Bavit 31. Date filed (Month, Day, Year) APR 1 7 2	UUB KA	wa &	4	will					
_		_										

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistras Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2006 APRIL 15, **Physician** CAROLYN MARIE BAMBERGER 9:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WALDORF 2209 PINEFIELD COURT CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | SEPT 11, 11 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗓 F PENNSYLVANIA 190-32-8767 64 Yrs 1941 Director Usual Residence of Decedent death with the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r then "naturel", or iteme 23e or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 X No MARYLAND CHARLES WALDORF Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2209 PINEFIELD COURT 20601 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. Affiled Polices? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 2 Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other then College (1-4or 5+) TRAINING MANAGER U.S. GOVERNMENT permit. Peges 1 and 2 should be file Department of Heeth and Mental Hy Important: If Item 27 1e marked othe eny injury or other treumatic event, 20ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JACK CROPPER NANCY ARNOLD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RICHARD E. BAMBERGER - SPOUSE 2209 PINEFIELD COURT, WALDORF, MARYLAND 20601 20a. Method of Disposition

1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State SACRED HEART CEM. 4 ☐ Donation 5 ☐ Other (Specify) 19, 2006 LA PLATA, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HUNTT FUNERAL HOME Suchanu M00053 3035 OLD WASHINGTON RD., WALDORF, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) multiple Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physicien Physician/Medical use as IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? res 2 certificete 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Certification; To Sesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation M filled in by the **Director:** 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospital within 24 hours of To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 028352 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISHAN MATHUR, MD, 3500 OLD WASHINGTON RD., #102, WALDORF, MARYLAND 20602 31. Date filed (Month, Day, Year) 32. Signature State APR 1 7 2006 Registrar

			1 - For State Registrar	State	of Ma	ryland	d / Depa <i>Cer</i>			lealth a Death		ental H	-	ene () ()	6	13565	i
	Physicia	an	1. Decedent's Name (First, Midd									2. Date of I Month		Day	Year	3. Time of Death	
	/Medic	al	OWEN HARRY BLA 4a. Facility Name (If not institution		number)			4b. City.	Town, or	r Location o		APRIL	14,	2006 4c. County	of Death	7:30 P	
	Examin	er	MULLENNIUM HEALTH 8	TO DOT 1		CENIE	R			HINGT				PRINC		RGE	
	Funeral Director		5. Social Security Number 214–18–8691	6. Sex 1 ☐ M 2 ☐ F		(In yrs. Ia	ist birthday) Yrs.	Il Under Months	1 Year Days	If Under 2 Hours		8. Date of I (Month,	Birth Day Y	1919		ace (State or Foreig	n
_			Usual Residence of Decedent								1	4111011					_
	ehow	5	10a. State 10b. Count				Town or Lo								10	0d. Inside City Limits 1√2 Yes 2 □ No	
	28a-f	Director	MD CHA	RLES		BKYAI	NS ROA	10f. Zip	Code				100	. Citizen of W	/hat Coun	- A	_
3	23a or		7050 DADDY'S PL	ACE					0616					ITED S			
	's arier deem with me maryla ', or iteme 23a or 28a-f ehov cantrar must be notified at	Funeral	11. Marital Status	12. Was D	ecedent E	ver in U.S	3. 13. V	Vas Deced	ient of H	ispanic Orig	gin? (Spe	cify Yes or Rican, etc.)	No-		- America		
3	/z nours aller deen with me maryland natural', or Iteme 23a or 28a-f show Lical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Ma 3 🖫 Widowed 4 ☐ Divorce	II Yes.	es 2 X No Give or Dates:	0		1□Yes	2 ₹ No	Specify:				Specify.		ACK	
5	natura lical E		15. Decede (Specify only highe	nt's Education			16a. Deced	dent's Usua	I Occupa	ation	t of workin	10	16	b. Kind of Bu	siness/Ind	lustry	_
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3	0.0		17. Father's Name (First, Middle	, Last)			OPEN	RATOR		18. Mothe	er's Name	(First, Midd		iden Sumam		EVILIENT	_
Ξ.	s 1 and 2 should be filled w I Heelth and Mental Hygier Item 27 Is marked other tr other traumatic event, ILI	To Be	ARTHUR HARRY B	LAND										N BLAN			
	le ma		19a. Informant's Name/Relation	, , , , , ,				-						City or Town,		•	
,	f Heelth Item 27 other tr		CHARLES BLAND/ 20a. Method of Disposition	SON	-	20b. Pla	ace of Dispo	sition (Nan	ne of		<u> </u>	ate CNA		c. Location -			
5			1 Burial 2 Cremation 4 Donation 5 Other (om State	ce	metery, cren	natory or o	ther plac	. 1	DDTI	10 2		BRYAN			
3	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service		Jul	- PACE				ss of Facility				NERAL			
3	8258				<u>OHNSO</u>						ROAI	O, INI	IAN	HEAD,		•	
	- 1		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications the t only one cause of	at caused ton each line	the death. e.		į.	1	n	/	11				Approximate Interval Between Onset and Death	
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E	Examiner			, bue	117	2 der	ly m	- Co	vin	an lo	nte	ra I	Dis	ease		20 years	2)
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3	cate be executed physicien and s the burial-transil	edicai E		L _d											ap and a second		
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	ettending for use as	lan/	23b. Was decedent pregnant in the past 12 months?		e birth 2	Fetal	death 3	Ectopic pr						23d. Date Mor	of delive	ry Day Year	
,	ine law requires merme deam cerm sie hes been signed by the ellending bage 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at t	ime of de	ath 5∟] Other (sp	ecity)				-			,	
	s mer pned b	by Pt	Part II. Other significant condit	ions contributing t	o death but	t not resul	Iting in the ur	nderlying c	ause give	en in Part I.	. /	.23e. Di	d tobac	cco use contr	ibute to th	e cause of death?	
Š	been sig		Humorr)	ragie.	Str.	he	, Dy	STRK	any	la G	-tw.	50) 11] Yes	2/2/No	3 🗌 Proba	ably 4 Unknown	1
	hes be	Completed	Jeizure	1150	rde	V,1	4/0 Z	IVEr	FICE	11051	15	24a. W	topsy	P	rior to con	sy findings available apletion of cause of	э
5	r this certificete he		+ bleed +	unen	ua,	Adv	unce	of A	gi			1 ☐ Yes			eath? Yes	2 No	
	s certil	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	☐ Inpatien	ıt 2∏F	R/Outpatien	t 3 DO	Oth	er /		(Check onl		ce 6 □Othe	r /Saasih		_
5	th. After thi funeral o		27. Manner of Death	28a. Da	ate of Injury		28b. Time of		8c. Injun					injury occurre		/	_
5	eath. for: Af the ful	catic	1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Could	igation				М	1 🗆	Yes 2 □ N							
	efter d Direct In by	Certification;		mined 286. Pl	ace of Injui uilding, etc.	ry - At hor (Specify)	ne, farm, str	eet, factory	, office		2	281. Location City or	n (Stree Town, S	et and Numbe State)	er or Rural	Route Number,	
	to fine hospitel or Attending Prysician: Within 24 hours effer death. Within 24 hours effer death. Completely filled in by the funeral director, g		29a. Certifier 1 Certify	ing Physicien: To	the best of	f my know	vledge, death	occurred	at the tin	ne, date and	d place, a	and due to th	ne caus	se(s) and mai	nner as sta	ated.	
:	the H the Fi nplete	Medical	one)		e basis of a	examınati ed.	on and/or inv				un occurre	at the tim	,			` '	
١	To No	2	29b. Signature and title of certifi		- 10 1		Mai	290	D/	e number	237	1 1/11	29d	Date signed	(Month, L	Jay, Year)	
	16		30. Name and address of person	who completed of	ause of de	ath (Item	23a) (Type	Print)	VV	6-	- //	inst	1	1/17/	106		
	pe 2		10 St. Pa	Frich	Dr =	0		wald	ort	m	200	103	Rec	dard li	Fa.	cill was	
	Sta	te	31. Date filed (Month, Day, Yea	7 2000	2. Megistrai	r's Signati	ure /	Last.	0	,							

			1 - For Stata Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F ertificate of		d Mental Hy	giene Reg. No.	006	13566
3.2	Physici	an.	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Theodore Nathan E					April	12	2006	5:40 P M
	Examin	er	4a. Facility Name (If not institution, give s Anne Arundel Medi		r	4b. City, Town, o	apolis	eatn	4C. (County of Death Anne A	
	Funeral	· 30 -	5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	If Under 1 Year	If Under 24 H		th Voor	9. Birth	nplace (State or Foreign
	Director		5/9-12-9/15	M 2□F	94 Yrs.	Months Days	Hours Mi	July 3	1, 19		ennsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation		, ,			10d. Inside City Limits
	Mary	to	Maryland Anne Aru	ndel		A	nnapolis	5			1 ☐ Yes 2X No
	be filed within 72 hours after death with the Maryland thygiene. At Hygiene. d other than "natural", or Items 23s or 28s-f show event, I'm Madical Examinar must be notified at	Director	10e. Street and Number	•		10f. Zip Code	24.404		10g. Citiz	en of What Cou	-
	s 23s		1972 Marconi Circ	LE 12. Was Decedent B	Turnin II S 12	Was Danidad at 1	21401	/G	. 1	U.S.A.	
^	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2XM/Married	Armed Forces? 1 ☐ Yes 2 🔀 N		Was Decedent of I	an, Mexican, Pu	erto Rican, etc.)	,	Black, White	e, etc.
2	ral', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2XXXvo	Specify:			Specify:	White
0500-617	"natu	Completed	15. Decedent's Edu (Specify only highest grade	cation co <i>mpleted)</i>	(Giv	edent's Usual Occu _l e <i>kind of work done</i> DO NOT use retire	during most of v	working	16b. Kin	d of Business/l	ndustry
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and	e filed at Hygid Lother vent, I	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle		Sumame)	
<u>X</u>	should be ind Mental I marked o	70	Samuel Black					e Hurwitz			
	12 a 14 a		19a. Informant's Name/Relationship (Ty.) Metta Black/wife	pe, Print)		ing Address (Street 72 Marcon					
<u>ရ</u>	tea than		20a. Method of Disposition		20b. Place of Disp			Date		ation - City or 1	
Ē	Page nent o nnt: #		1XDBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			'	/18/2006	Anna	polis,	Maryland
baltimore,	permit. Pages 'Department of h Important: If ite any Injury or ot once.		21. Signature of Funeral Service License	Lil		2. Name and Address Ad					al Home , MD 21401
	Physician		23a. Pan1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each lin	the death. Do not er e. Logenic Sh		ng, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death Minutes
	/Medical Examiner		resulting in death)		a consequence of):						_
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	outed id ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	COPD							years
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2/00	cate b physic the b	dlcal		l							
o X D	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					2	3d. Date of deliv	very
ה מ	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at 9□ Unknown		□Ectopic pregnanc □ Other (specify) _	у			Month	Day Year
r Ö	that the	Phy	9 ☐ Unknown Part II. Other significant conditions cor		ut not resulting in the	underhing cause an	ven in Part I	23e Did	tobacco us	se contribute to	the cause of death?
ďs,	signe Id be c	d by	Tarrin other organical contained	inibating to dodino	at not resulting in the	underlying cause gr	on in and i.		Yes 2		bably 4 Unknown
Ита! несога	tw require been sign should b	lete						24a. Was		24b. Were aut	topsy findings available ompletion of cause of
H	The lav	Completed						auto perf	psy ormed? 2 XX No	death?	ompletion of cause of
/Ita	ysician: The k his certificate ha director, page 2	Be	25. Was case referred to medical examiner?					Death (Check only			
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	To the Hospital within 24 hours of To the Funeral completely filled	edical			examination and/or i						
	To the within 2 To the complet	W	29b. Signature and title of certifier	11/1	.1001	29c. Licen:				signed (Month	n. Day, Year)
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			30. Name and address of person who construct of Steven Resnick A		eath (Item 23a) (Type lel Medica		2001 Ma	edical Da	rkws	7 ∆nnar	21401 colis, MD
*	Sta	ate	31. Date filed (Month, Day, Year)	\$2. Registra	ar's Signature		2001 196	Julicai Pa	ınway	vindi	OTTS! IND
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State of Maryland / Department of Health and Mental Hygiene 3567 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April ^{Day}2006 Physician 11, Mary Olivia Burch Baranek 2:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Edgewater 3730 Boyd Drive 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 83 Dec. 8, 1922 Director 578-22-4480 Maryland Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 → No Directo Maryland Anne Arundel Edbewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3730 Boyd Drive 21037 Funeral IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Realton Self-employed 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Raymond Burch N. Grace Finnell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4193 Carrs Ridge Rd. Edgewater, MD. 21037 Kathy M. Grimley/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. Burial 2 ☐ Cremation 3 ☐ Removal from \$tate Lakemont Memorial Gardens 4/18/06 Davidsonville, MD. 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Syneral Services Licensee 22. Name and Address of Facility Geo. P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037 23a. Part1 Enter the disease, or complications shock, or heart failure. List only one cay had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** On-Smal 21/24895 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 20 No 1 ☐ Yes 2 ☐ No 1 Yes After this certification, I Be 25. Was case referred to medicat 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home SP Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 2 Accident 1 Yes 2 No Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours of To the Funers! Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Panine Weing, MP APril 11,2006 D52830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgak Road #300, Annapolis, ND 21401 Jeanne Werner, MD egistrar's Signature 31. Date filed (Month, Day, Year) State APR 14 2006 Registrar

		1 - For State	State of M		d / Depa	ırtme		alth and	Mental H	ygien	e 21	ne.	1256
	-	Registrar 1. Decedent's Name (First, Middle	, Last)						2. Date of D	Reg. No	. E.u. %	00	3. Time of Death
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s 1 end 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or itema 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at		Sharon L. McGla		ghter		-							
the metal		20a. Method of Disposition		20b. P	lace of Dispo	sition (N	ame of	1	Date	20c. L	ocation -	City or To	wn, State
mit. Pages pertment of portant: if if y injury or of		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (Sp		- 1	ro Cre	-		1	-2006	Ba1	timo	re. M	ID.
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fo th within fo the	₩.	29b. Signature and title of certifier				2:	c. License r	number		29d. Da	ate igned	(Month, L	ay, Year)
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		30. Name and address of person v	who completed cause of c	death (Item	,23a) (Type.	Print)		, , , ,	Δďi	tva	d lobra	MD	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Edward Spencer Biddle April 2006 0100 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Manor Healthcare Center Rising Sun Cecil 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye DEC 20, 1 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□F **Director** 161-16-7937 92 1913 Mary1and Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits Item 27 is marked other then "netural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 V Yes 2 □ No Director New Castle Delaware Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Manns Avenue 19711 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: δ Specify: 3

Widowed 4 □ Divorced Year or Dates: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
State Department (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If Item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) of Agriculture Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy R. Biddle Mary DuHamel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry W. Mason/Son-in-law 91 Shelton Lane, Rising Sun, Maryland 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 25. 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Rosebank Cemetery 2006 Calvert, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee eny Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ peq 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2000 has page 2 certificate 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending 1/SNatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation the Funeral Director: apletely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29d. Date signed Month, Day, Year) 0 29b. Signature and title Certifie 29c. License number 30. Name and address of person who completed caus

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State

Registrar

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

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altillore, marylaliu zizio-0030	rmit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland	ipaniming or nami sid unwenter trypense. portant: if item 21e marked other then "natural", or itema 23a or 28e-1 ehow y injury or other treumatic event, the Medical Examiner must be notified at	

			For State Registrar	State of Ma	Cei	rtificate of			2006	13571
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936	al', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 XYes 2 □ No	Specify: Nic	caraguan	Specify:Wh	ite
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	of Health Item 27 other tr		Charlotte Benard/1 20a. Method of Disposition	Wife	14660	Seneca :	Road Germ	nantown, M		
Dor	Pages nent of h ant: If Ite		1 ☐ Burial 2 【 Cremation 3 ☐		20b. Place of Dispo cemetery, cres Chesapeak			.11 109	Oc. Location - City o	Maryland
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Ž	nysical lis ce direc	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatier	nt 3 DOA	100	lome 5 Residen	ce 6 □Other (Sp	ecify)
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Di∨	2 = = =	Certification:	4 Homicide determined	building, etc.	ry - At home, farm, str . (Specify)	eet, lactory, office		City or Town,		Rural Route Number,
	8 5 6 8		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge, deatl	occurred at the ti	me, date and place	, and due to the cau	se(s) and manner	as stated.
	To the Hos within 24 ho To the Fun completely f	Medica	Undy	iner: On the basis of and manner stat	ed.					
	To To Co	2	29b. Signature and title of certifier			29c. Licens	e number	290	I. Date signed (Moi	nth, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) APR 1 8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The Germanteun Fell way

			. For	State of Ma		d / Depa	artmer	nt of H	ealth and	•		•	13572
			1 - State Registrar			Cer	tificat	te of L	Death		Reg. No	.	7 0 0 7 44
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ì	Examin		4a. Facility Name (If not institution, give						Location of Deat	h		. County of Dea	
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	Funeral Director		218-34-7822	ex 7. Age	e (In yrs. Ia 68	ast birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hrs Hours Min.		y, Year,		thplace (State or Foreign ountry) yland
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation						10d. Inside City Limits
	Maryland -f show lied at	ō					04,1011						1 ☐ Yes 2 🕅 No
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5	death with the ms 23a or 28a rnust be notif	ă	4209 Cabin Creek	Road			101. 21	2164	.3		rog. o	USA	odiniy :
) :	ns 23	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S	3. 13. V	Nas Dece			Specify Yes or No)-	14. Race - Am	erican Indian.
	ter o	Ξ	1 ☐ Never Married 2 🕅 Married	Armed Forces?					ispanic Origin? (S n, Mexican, Puer	to Rican, etc.)		Black, Whi	
3	al', o	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 X No	Specify:			Specify:	√hite
0500-c	72 hours after natural', or Ite	Completed	15. Decedent's Ec (Specify only highest gra	ducation		16a. Decec	dent's Usu	al Occupa	ation	rkina		Kind of Business	
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A	e filed within al Hygiene. I other than ' vent, the We	S	12			Depui	су		45.44.4.1.11			artment	
	ild be fi lental H kad ott ilc ever	Be	17. Father's Name (First, Middle, Last)	ł.						me (First, Middle			
2	2 should be and Mental is marked is marked sumatic ev	ို	John W. Bramble 19a. Informant's Name/Relationship (Tuno Rejet		10h Mailin			Mary Kat				Tie Codel
≦ :	o € ⊳ =		Neva M. Bramble/W	**					eek Road				
ย์	Health tem 27 other tr		20a. Method of Disposition		20b. Pla	ace of Dispo metery, cren				Date		ocation - City or	
Baltimor	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donatien 5 ☐ Other (Specification) 5 ☐ Other (Specification) 1						Cem. 4/1	8/2006	Hur	lock, M	arvland
	mit. I		21. Signature of Funeral Service Liger		2				ss of Facility		_	-	<u> </u>
ä	Depa impo any ir		Dermud X	Jall Sell	w	Ze 1	ller 06 Ma	rune ain S	treet,	e, P. O. East New	Bo: Mai	ket, MI	21631
П		- 1	23a Part. Enter the disease, or com shack, or heart failure. List only	plications that caused one cause on each lir	the death.	. Do not ent	er the mo	de of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
γ F	hysician		Immediate Cause (Final disease or condition	llepa		cei	lul	ar	(arc	inom	a		Onset and Death
	/Medical		resulting in death)	Due to (or as			00-0	CCT	care	CIT COLL	-		I WOOK
	Examiner	,	Sequentially list conditions.	b									
	ed self	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):							
	be executed iclan and burial-transIt	xan	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of);					-		
2	te be executed ysiclan and ne burial-transit	calE	N.	d									
9	death certificate attending physi	edic											
ŏ	death certifical e attending phi od for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			DEctopic p	reananar				23d. Date of de	livery
מ	deat he atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (s					Month	Day Year
J.	that the de led by the s detached t	Physician/Medi	9 Unknown										
S,	50 0	by	Part II. Other significant conditions of	onthouting to death b	ut not resu	iting in the ui	naerlying (cause give	en in Part I.	238. Did 1		1.00	o the cause of death? robably 4 □Unknown
cords	w require been signal	Completed											
Hec	sician: The law certificate has b irector, page 2 s	mp								24a. Was auto	nsv	prior to death?	utopsy findings available completion of cause of
											2 N	o 1 ☐ Ye	
VItal	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatien		OA Othe	or	ath (Check only delay		2 TO::- (2-	
O	ding Phys th. After this funeral dir	-	27. Manner of Death	28a. Date of Inju (Month, Day		28b. Time of		28c. Injury	/ at	28d. Describe			эспу)
0	nding uth. r: Afte e fun	atlor	1 Natural 5 Pending 2 Accident investigation		y rear)	Injury	м	Work	<br Yes 2 ☐ No				
DIVISION	or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	3 Suicide 6 Could not b	28e. Place of Inju-	ury - At hor	me, farm, str	eet, factor	y, office		28f. Location (City or To	Street a	nd Number or R	lural Route Number,
5	Ital or rs aft rat Dir led in	Cer											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	nysician: To the best of miner: On the basis of and manner sta	f examinati	vledge, death ion and/or in	n occurred vestigation	at the time n, in my of	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s date an	s) and manner a ad place, and du	s stated. e to the cause(s)
	To the within 2	Me	29b. Signature and title of certifier				29	c. License			29d. Da	ate signed (Mon	th, Day, Year)
}	->-0		Mullia	m 1/20	1			14	3238		AF	nlis	,200h
			30. Name and address of person who	sompleted cause of d	leath (Item	23a) (Type	Print)			C.	h a	1 =	,2006 MD 21613
			William	Dair	10	000	TCIII	104	e St.	Cam	10	age,	MV 21613
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 9 20	32 Registra	ars Signat	ure	and i	P					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UU 6 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth April 2006 11:15 AM Clara B. Crank 4b. City, Town, or Locetion of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Hyattsville Prince George's Sacred Heart Home | Months | Deys | Hours | Min. | B. Date of Birth (Month, Pay, Year) | South Carolina 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdev) Months 1 □ M 2 🖟 F Yrs. 578-30-2086 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 ☐ No Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 1320 Holbrook St., N.E. United States 20002 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 █️No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Nurse Private 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Benjamin Williams Elese Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Crank Cooks/Daughter 1320 Holbrook St., NE Wash., DC 20002 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date etery, crematory or other place) Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Mem. 4/19/06 Laurel, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death UROSEPSIS Immediate Cause (Final disease or condition resulting in death) unkhown Uhknows Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Severe dementia, Cerébrovas cula 24b. Were autopsy findings available prior to completion of cause of death? accident, hyportension 24a. Was an autopsy performed?

Physician /Medical Examiner Physician/Medical Examiner

igned by the attending physician end be detached for use es the buriel-trensit

affar deeth. I Director: After this certificeta has been sig ad in by tha funerel director, pege 2 should t

ρ

Be Completed

Certification: To

25.

27

29a. Certifier

or Attending Physician: The law requires that tha daath certificate be executed

Division of Vital Records, P.O. Box 68760.

pamit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ahow any injury or other traumatic event, the Medical Examinat must be notified at

Baltimore, Maryland 21215-0020

Physician

/Medical

10a. State

Funeral Olrector

ģ

Completed

Be

Examiner

Funeral

Director

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

ack only one)

1 ☐ Yes 2 ☐ No

Was case referred to medical					26. 1	Place of Death /Che
examiner? 1 ☐ Yes 2D No	Hospital	1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4	Nursing Home
Manner of Deeth		Dete of Injury	28b. Time of		c. Injury et	28d. [

5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred

1 Natural

2 □ Accident 5 Pending investigation 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature end title of certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Chowdhy, mo

143/21

30. Neme end address of person who completed ceuse of death (Item 23e) (Type, Print)

NURUL CHOWDHURY, MD; 15216 DINO DRIVE; BURTONS VILLE, MD 20866

State Registrar 31. Dete filed (Month, Day, Year) APR 1 7 2006



To the Hospital within 24 hours a To the Funeral I completely filled

			1 - For State Registrar	State of Marylan		artment of F		Mental Hy	/giene	1116	13575
	7 %		1. Decedent's Name (First, Middle, Las	7)	7.7.			2. Date of D Month		. Va	3. Time of Death
7	Physici /Medic		JAMES GILBERT	COX SR.				Apri	$1 1\overset{\text{Da}}{3},$	2006	4:04PM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of De	ath	4c.	County of Deat	
*			Prince George's			Chever					George's
П	/ Funeral		5. Social Security Number 6. Security Number 11.	NM 2CTE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, D			nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	68				Sep.	8, 1	937 We	st Virginia
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	a-fel	ctor	Maryland Prince	George's I	andove	r Hills					1X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Co	untry?
	ath w		7224 Marywood S			2078				U.S.A.	
	er de Iteme	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces?		Was Decedent of H f Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	 Race - Amer Black, White 	
5	hours after death with the Maryland turel', or Iteme 23e or 28e-f ehow al Exertiner - well be notified at	by F	3 Widowed 4 MDivorced	1 XXYes 2 No 195 If Yes, Give Year or Dates: 195		1 ☐ Yes 2 🖾 No	Specify:			Specify:	hite
5-0036	be filed within 72 hours after death with the Marylan stal Hygiene. ad other than "natural", or Iteme 23e or 28e-1 showers. The Markinal Experiment was been collised at	ted	15. Decedent's Edi	ucation	16a. Deced	dent's Usual Occup	ation		16b. Ki	nd of Business/l	
7	within 72 ene. than "nai	ple	(Specify only highest grad	Coilege (1-4or 5+)	life. l	kind of work done DO NOT use retired	during most of v d)	vorking			
Z127	e filed wi Il Hygien other th	Completed	11			Carpente					Business
Maryland	be fit ntal H od ott	Be	17. Father's Name (First, Middle, Last)					lame (First, Middle		,	
Ĕ	d Men narke	은	Gilbert Walden 19a. Informant's Name/Relationship (T		40h Maille			aura Bell			
<u>B</u>	d 2 si th an 17 is r		Arlies I. McCally			g Address (Street Δrkhavan					and 20779
စ်	es 1 and 2 should be of Health and Mente of Health and Mente of Item 27 is marked rother traumatic er		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place	Ku., 11	Date Date		Mary La cation - City or 1	
<u> </u>	nit Pages barment of for ant: If It in ury or o		1 ⊠Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	tomovar mont state		natory or other plac coln Cemete		/18/2006	Dana		Maryland
altimore,	교통문술		21. Signature of Funeral Service Licen			. Name and Addre	ss of Facility	Gasch's	Fune	ral Home	Maryland P A
ñ	Depar Impo		+allusti	11/4/	4	739 Balti	imore Av	enue, Hy	atts	ville, N	D 20781
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications hat/caused the death	n. Do not ent	er the mode of dyin	ig, such as card	iac or respiratory	arrest,		Approximate Interval Between
10 m	Physician		Immediate Gause (Final disease or condition	a//Acute Myoc	ardia1	Infarcti	ion				Onset and Death Hours
<u>.</u>	/Medical Examiner		resulting in death)	Due to (or as a conseq		Intarces					nould
	Lxamille	_	Sequentially list conditions,	b. Atheroscle		Cardiovas	cular D	isease			Years
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence or):						
,	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				-		
9/90		Ical		d							
Õ	certificate nding phys	Medi	IE SENALE								
gox	tendii tendii rr use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta.		Ectopic pregnancy	,		2	23d. Date of deliv	•
	the atter thed for n	Physician/Med	1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown	eath 5□	Other (specify)				Month	Day Year
Ţ.	that the		Part II. Other significant conditions co	ntributing to death but not resi	ulting in the ur	deriving cause giv	en in Part I	23e Did	tobacco u	se contribute to	the cause of death?
ecoras,	w requires that the death certifica been signed by the attending pl should be detached for use as t	d by	Diabetes Mellit		g si	radily mg oddoo giv	on in rate i.				bably 4 🖺 Unknown
Ö	law req as been 2 shou	lete	Pulmonary Veno-	Occlusive Disc	222			24a, Wa	20	24h Were aut	opsy findings available
	The lav	Completed	Turnoliary veno	occidatve Dise	ase			auto perf	psy ormed?	prior to o	ompletion of cause of
		e l	25. Was case referred to medical				26. Place of D	1 ☐ Yes	2⊠ No	1 🗆 Yes	2□ No
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 🖾	ER/Outpatien	t 3 DOA Oth	00	Home 5 Res		3 □Other (Spec	fy)
	ng fter mer		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor	y at k?	28d. Describe	how injury	y occurred	
20	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No				
UNISION	l or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif)	ome, farm, stre	eet, factory, office		28f. Location City or To	Street and wn, State,	d Number or Rui }	al Route Number,
_	portal ceral		29a. Certifier 1 ★ Certifying Phy	sician: To the best of my kno	wledge death	occurred at the tr	no data and pla	on and due to the			
	24 h 24 h Fun etely	edical	(Check only 2 Medical Exami	ner: On the basis of examinal and manner stated.	tion and/or inv	estigation, in my o	pinion, death oc	curred at the time	date and	place, and due	to the cause(s)
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	e signed (Month	Day, Year)
	4		► I// ∧ (/ rus	com	рз	2261		Λ	4/14/20	06
	131		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, I					1/14/20	00
	3		Richard J. Feldma	n, M.D. 9500	Annapo	lis Rd,	Lanham,	Maryland	207	06	
	Sta Registr	_	APR 1 4 2006	32, Registrar's Sign	TUF9						

State of Maryland / Department of Health and Mental Hygien 3576 1 - For State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 700 M /Medical 4. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner 4 Hrs. If Under If Under 1 7. Age (In vrs Jast birthday) 5. Social Security Number 6 Sex **Funeral** Days Hours Min. 1 M 2 N Yrs. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County tems 23s or 28a-f show 1 Yes 2 No r than "natural", or ttems 23s or 28s-f shove the Medical Executes must be notified at Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number by Funerai 12. Was Decedent Ever in V Armed Forces? 1 Yes 2 No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 2**X** No 1 TYes Specify 3 Widowed 4 ☐ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working iffe. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) t of Health and Mental Hygi if item 27 is marked other or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 8 ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Baltimore, Date Method of Disposition Pages 1 Surial 2 Cremation 3 Removal from State Department of important: if any injury or once. 5 ☐ Other (Specify) 21. Signatule of Fun ral Service Link nsee permit 22. Name and Address REET NE DC 2001 23a. Part1. Enter the disease of complications that caused the death. shock, or hear dailure. If st only one cause of each line.

Immediate Cause if inal disease or condition resulting in death) Approximate Interval Between Onset and Death To not enter the mode of dying, such as calculate or respiratory arrest, RS Physician /Medical Due to (or as a o nsequence of) Examiner tersi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due as a consequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending f IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9□ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has b ector, page 2 sl autopsy performed? Yes 27 No certificate ! 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 20 No 27. Manner of eath Hospital: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA dire 2 1 🔲 Inpatient this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28h Time of 28c. Injury at Work? Certification: After t Injury 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funarat Director: 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined filled in by 4 - Homicide ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier DC. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9500 Jaman Lichard mi 31. Date liled (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2006

Registrar

			For State Registrar	State of Maryland		rtment dificate			nd Mei		iene	6	13577
¥	8 0	28	1. Decedent's Name (First, Middle, Last	')					2.	Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		Elizabeth Jane	Cunningham						pril	1	06	8:05 P M
	Examin	ner.	4a. Facility Name (If not institution, give			4b. City, To			f Death		4c. County		
		ş.,	Anne Arundel Medi			Ann	napo	lis Under 2	24 Hrs o	Data of Blate	Anne		
	Funeral		5. Social Security Number 6. Se	74 NTE	st birthday) Yrs.		Days	Hours	Min.	Date of Birth (Month, Day,	^{Year)} 1920	Co	nplace (State or Foreign untry) "Yland"
	Director	-	579-44-1266	86	110.				1	eb. 4,	1920	Mai	yranu
	land		10a. State 10b. County	10c. City,	Town or Lo	cation							10d. Inside City Limits
	Marylan-f show	ğ	MD Prince G	eorge's Bo	owie								1X Yes 2 No
	28s	rec	10e. Street and Number			10f. Zip C	ode			1	0g. Citizen of	What Co	untry?
	3a o	Funeral Director	16010 Excalibur R	d. Apt. D-321			2	20716				USA	
	death	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Deceder	nt of His	spanic Orig	gin? (Specif	y Yes or No-		ce - Ame	ncan Indian,
9	affer or Its	Ī	1 Never Married 2 Married	1 Tes 2 XNo		1 ☐ Yes 2 【			, 1 0010 110	un, 0.0.,	Specia	h/-	
215-0036	within 72 hours affer death with the Maryland ene. then "naturel", or Iteme 23e or 28e-f ehow fre Madical Examinat mail be natified at	d by	3 ∰Widowed 4 ☐ Divorced	Year or Dates:								Wh	ite
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121	Mithin ne. hen.	mp	Elementary/Secondary (0-12)	Colfege (1-4or 5+)			_				Medi	aa 1	
121	lied v tygie her t		17. Father's Name (First, Middle, Last)	3	T(e	egiste				irst. Middle. I	Maiden Sumai		
Maryland	ntal H	Be								Skinne		,	
Ž	d Me nark natio	ပ္	John Wesley Simmo		19h Mailir	na Address (Street a				, City or Town	. State. 2	Zip Code)
Ma	d 2 sl th an 7 ls r traur	i	Donald E. Cunning			B Holl					zille,		
	1 an Heali em 2		20a. Method of Disposition	20b. Pta	ace of Dispo	sition (Name	of		Date		20c. Location		
Baltimore	ages of of or or		1 Burial 2 □ Cremation 3 □	Hemoval from State	-	natory or oth			04/15	/2006 1	rince	Frec	lerick, MD.
Ë	it. Partimentant		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen			2. Name and							erick, rib.
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel; or iteme 23e or 28e-1 ehow any injury or other traumatic event, it who are injury or other traumatic event, it who lied Examinating to any injury or other traumatic.		PR			512 NW			Dea_	Bowie,	eral Ho	me 2071	5
700	44		23a. Part1. Enter the disease, or comp	olications that caused the death.					_			2071	Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each fine.									Interval Between Onset and Death
H	Physician /Medical		disease or condition resulting in death)	. Pheur		ia							1 2 hours
- 5	Examiner			Due to (or as a conseque		· La	do	7.7					77 has
74%		- o	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque	ence of):	7 14		10					7 2 7 107 3
	insit	Examiner	cause. Enter Underlying Cause (Disease or injury										
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89	ificate g phy as the												
Box	death certifica e atfending ph id for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pred						ate of del	
m	death e atfe d for	icia	in the past 12 months?	4 Pregnant at time of de		Other (spec					М	onth	Day Year
0	the by th ache	hys	9 ☐ Unknowh	9□ Unknown									
ď.	w requires that been signed to should be deta	y P	Part ff. Other significant conditions of	ontributing to death but not resul	lting in the u	inderlying cau	use give	en in Part I.		23e. Did to	bacco use cor	tribute to	the cause of death?
Ď	requires een sign tould be	pa	LUPUS							1 🗆 Y	es 2□No	3 🗌 Pı	obably Unknown
S	law re as bed 2 sho	piet								24a. Was a autops	n 24b.	Were au	utopsy findings available completion of cause of
Division of Vital Records,	o = 0	Completed								perfor	med? 2.⊿No	death? 1 ☐ Yes	_
ital	olcian: Th certilicate rector, pag	0	25. Was case referred to medical					26. Place	of Death (Check only or			
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0			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28	c. Injury Work	at	28	d. Describe h	ow injury occu	rred	
Ö	Attending r death.	atic	2 Accident investigation	1		М	1 🗆 `	Yes 2 🗌					
Ξ	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, st)	reet, factory,	office		28	f. Location (S City or Tow		ber or R	ural Route Number,
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	To the Hospital or Attend within 24 hours affer death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only 2 Medical Example)	ysician: To the best of my knowniner: On the basis of examination and manner stated.	vledge, deat ion and/or ir	th occurred a evestigation, i	t the tim	ie, date an pinion, dea	id place, and th occurred	d due to the c at the time, c	ause(s) and n late and place	anner as , and due	s stated. e to the cause(s)
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R	(5)		30. Name and address of person who	4	E .	Do-L	(1.1 A.	_ /	L	alic	Mel	214	01
			31. Date filed (Month, Day, Year)	2. Registrar's Signat	cli ca	, far f	CWA	7 1	rnap	0113/	010	011	
4	Regist	ate rar	APR 1 3 200		for	de la							

			For State Registrar	State of M	aryland / De	oartmen e <i>rtificat</i>			and M	F	Reg. No.	106	135	78
	Physici		Decedent's Name (First, Middle, La Lemroy	ast) Colem	an					2. Date of Dea		6 Year	3. Time of E	
	/Medic	_	4a. Facility Name (If not institution, gi			4b. City,	Town, or	Location of	of Death	117		unty of Death		P *
	CXdIIIII	eı	Doctor's Hospi			Lanl	ham				Princ	ce Geo	rges	
	Funeral Director			Sex 7. Ag 11∑ M 2□ F	e (In yrs. last birthda 83 Yrs.	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day June 10	1922	9. Birth Se Im	nplace (State or untry) AL.	Foreign
	/land		10a. State 10b. County		10c. City, Town or								10d. Inside City	
	and	Director	D.C.		Washii	igton							1 ₹ Yes	2 🗌 No
	with th	i Dire	10e Street and Number 809 Tewkesbury	Place N.W.		10f. Zip	Code	20012			10g. Citizen USA	of What Co	untry?	
036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at ADE.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 函Yes 2 ☐ If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Deced If Yes, spec		ispanic Ori in, Mexicar Specify:	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer Black, White ecify: B1		
5-0	72 ho	eted	15. Decedent's E (Specify only highest g.	Education rade completed)	16a. De	cedent's Usua ve kind of wo b. DO NOT us	al Occupi	ation during mos	t of worki	ng	16b. Kind o	of Business/I	ndustry	
121	within ene. then	dmo	Elementary/Secondary (0-12) UKNOWN	College (1-4or	5+)	tore 0		')			Fran	ning		
Baltimore, Maryland 21215-0036	id be filed ental Hygi kad other ic event,	To Be C	17. Father's Name (First, Middle, Las Lemroy R. Co					18. Mothe		(First, Middle, KNOWN	Maiden Sur	пате)		
Mary	nd 2 shou ilth and M 27 is mar r treumat	-	19a. Informant's Name/Relationship Brenda Davis / D	(Type, Print) aughter	19b. Ma 210	iling Address B Park	(Street a	and Numbe	er or Rura Bowi	e,MD. 2	r. City or ^T o 0721	wn, State, Z	ip Code)	
nore,	Pages 1 elent of Healuri, if item		20a. Method of Disposition 1 Burial 2		20b. Place of Discemetery, of	position (Narrematory or o	ther plac	ee)) _{ate} /2006		ion - City or i		
Baltii	permit. F Departm Importar any injui		21. Sign to re of Funer Service Lice		B					N T. RH WASHING				
	Physician /Medical Examiner	Examiner	23a. Part1. Inter the disease, or conshoot, or heart failure. List only media & author (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Acute Due to (or as b. Anoxi Due to (or as	Respirate a consequence of): c Encepho a consequence of):	ory Fa	ilur		cardiac	or respiratory ar	rest,		Approximate Interval Betw Onset and D	reen
). Box 68760,	it the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 \(\overline{\text{ZNO}}\) 0 □ Unknown	d	2 Fetal death	3 □Ectopic pi 5 □ Other (sp		,			23d.	. Date of deli		ear
Is, P.O.	es tha gned be de	þ	Part II. Other significant conditions	contributing to death I	out not resulting in the	underlying o	ause giv	en in Part I			obacco use d		the cause of de	
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ta	sician: Th certificete irector, pag	0	25. Was case referred to medical				-	26. Place	of Death	1 ☐ Yes	2 🙀 No ne)	1 ☐ Yes	3 € No	
Ž	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 1 Inpati	ent 2 ER/Outpa	ient 3 DC	Oth Oth	25		me 5 ☐ Resid		Other (Spec	cify)	
o uo	ling After une		27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) Injur	of 2	28c. Injur Wor 1 □	yat k? Yes 2□		28d. Describe h	now injury od	curred		
Division of Vital	or Atten fter deat Sirector: in by the	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	jury - At home, farm, tc. (Specify)	street, factor	y, office			28f. Location (S City or Tov		umber or Ru	iral Route Numb	ier,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	cal	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis, and manner's	of examination and/o	investigation	i, in my o	pinion, dea	th occurr	ed at the time,	date and pla	ce, and due	to the cause(s)	
	To th Vithin To th compl	Me	29b. Signature and title of certifier	1 2	,	29	c. Licens	e number			29d. Date si	gned (Monti	n, Day, Year)	
	(15)		fruito	12/1	1012	M	OD	313	5 /		4-	- /2	-06	
	A.		30. Name and address of person wh 31. Date filed (Month, Day, Year) APR 1 3 2006	o completed cause of	death/(Item 23a) (Ty	oe, Print)	1 40	k R	1,2	anhan	1110	1. 0.	30906	5
100	Sta Regist	ate rar	APR 1 3 2006	82. Regist	rars Signature									

			. For	State of Maryland /	Depa	rtment of H	lealth and	•	•	12579
			= State Registrar		Cer	tificate of l	Death		g. No.	10012
	Physici	an	1. Decedent's Name (First, Middle, Last) John F. Coye					2. Date of Deat Month April 8,	Day Year	3. Time of Death 5:57 A M
	/Medic		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dea		4c. County of Deat	
	Examir	iei	Southern Maryland			Clinton			Prince Geo	orge's
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		year) 9. Birt	hplace (State or Foreign
1	Director		579-84-7947 Usual Residence of Decedent	M 2□F 46	Yrs.	Mortus Days	Hours	Nov 4, 1		ington DC
	land		10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Mary Per eh	tor	MD Prin	ce George Temp]	le Hi	11s				1 X Yes 2 □ No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23a or 28e-f ehow eumatic event. The Medical Expraner court by notified at	by Funeral Director	10e. Street and Number 4010 24th Avenue			10f. Zip Code 20748		10	og. Citizen of What Co USA	ountry?
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V			Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, White	
036	ours after ral', or Ite Exemine	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		Yes 2 X No		nto moan, otc.,		31ack
21215-0036	hin 72 ho en "netu Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16 completed) College (1-4or 5+)	a. Deced (Give life. L	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of w f)	orking	16b. Kind of Business/	Industry
21	d with giene.	LOC I	12	4	Lega	al Assist			Governmen	nt
Maryland	ould be filed v I Mental Hygie varked other t	To Be (17. Father's Name (First, Middle, Last) James Hector Coye					ame (First, Middle, M et Thomas	Maiden Sumame)	
Mary	s 1 and 2 should if Health and Menitem 27 is marke other treumatic	h 3	19a. Informant's Name/Relationship (Ty) Margaret Thomas - N						City or Town, State, 2	
lore,	Pages 1 and 2 nent of Health int: If item 27 ity or other tru	3	20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ R	20b. Place	of Dispo	sition (Name of natory or other place	(a)	Date	20c. Location - City or Washington	Town, State
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr gace.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	A. Ar	22	. Name and Addres	ss of Facility P	ope Funera		
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. De						Approximate Interval Between
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Que to (or as a consequence		26 5	leedi	4		Onset and Death
68760,	cate be executed obysicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					
P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	quires that n signed t	d by P	Part II. Other significant conditions con	tributing to death but not resulting	in the ur	nderlying cause giv	en in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	
Vital Records,	ne law require s has been si ge 2 should l	Completed by	ANOXIL	Encephs	10	palhy		24a. Was a autops perform	y prior to death?	stopsy findings available completion of cause of
a	sicien: The l certificate ha irector, page	ပိ	25. Was case referred to medical	Aspiration	10	neum.	h 1 M c	1 ☐ Yes 2 eath Check only on		2 No
>	ysicis is cert direct	To B	eyaminer?	ospital: 1 Impatient 2 ER/C	Outnatien	t_3 DOA Oth	oc		ence 6 ⊡Other (Spe	cifu)
ion of	nding Phys ith. :: After this e funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	. Time of Injury	28c. Injun Wor			ow injury occurred	3.17
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funesel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stri	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
	To the Hospite within 24 hours to the Funerel completely filled	Medical ((Check only one)	ilciam To the best of my knowled ner: On the basis of examination a and manner stated.	ge, death and/or inv	estigation, in my o	ne, date and plat pinion, death oc	te, and due to the co curred at the time, da	ate and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1 m D		29c. Licens	e number	C, 25	9d. Date signed (Mont	h, Day, Year)
(11) 21	,	30. Name and address of person who co	,	a) (Type,	- 4	, 5 5		74-08-	2006
700	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	3 5	outher	N AUG	SE	1) 2 20	0 3 2
	Regist	rar	APR 1 3 2006	plane it	good	w				

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar Anuradha Arun, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

10301 Georgia Ave. # 209, Silver Spring, Md. 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mont **Physician** 4:30 AM 2006 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 28233 Holland Crossing Road Marion DomerseT If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09-13-19 **Funeral** Days Hours 72 1**X**M 2□F Yrs. 214-32-1072 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Micdical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State MD 1 Yes 2 No DOMERSET Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21838 28233 vossing DOD tolland Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2.X If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kubberset BRUSH Maker ัณกา 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ordelia 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) Helland Marion, Un 21838 xossing 28233 Load 20a. Method of Disposition 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State John Wesley Comolog 04-13-2000 14 HRION
2. Name and Address of Facility
Ward Funeral Hame
30039 Hampoun Are Princes Anne, 5-2006 MARion * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Andle NO 2/853 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Cancen LUNG **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissaso or injury) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L ð Metastasi 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 2 No 1 Yes this certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 1 Fesidence 6 □Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide t certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie

State Registrar 305

31. Date filed (Month, Day, Year) APR 1

DHMH 17 Rev 1/2001

Pocomoke

32. Registar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

57

8 2006

Tenon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ne.-2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1BTTA 2886 8:10 PM Anna Will Carhart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIT HOSPITAL BRUTHORE SINM BALTI MORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 😡 F Director 72 259-44-6372 Georgia REFERE Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Finksburg Carroll 1 ☐ Yes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21048 1939 Carrollton Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specity: d WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Glenn Miller Anna Lucile Mulder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Depertment of Heelth ar
Importent: If Item 27 is
any Injury or other trau John G. Carhart, Jr- Husband 1939 Carrollton Road, Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/18/2006 Westminster, MD St. John Catholic 21. Si mature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home M01191 usti 91 Willis Street, Westminster, MD 21157 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRA GRANIAL HEMORRANGE 2 HOURS /Medical Due to (or as a consequence of): Examiner THROWBO PENIA (IL)KNOWA) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Vear 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Yes 2 ☐ WO Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after dec. 1 Natural 5 Pending Injury 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 055119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 240/ W. Belvedere Ave. GRNUCT Mi ISINA MOSPITAL BALTIMORE THOME 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State APR 1 7 2006 Registrar

Elizabeth Elizabeth Carr April 10 2006 10:11 a March 10 2006 10:11 a March 10 2006 10:11 a March 2006 2007			1. Decedent's Name (First,	Middle, L	.ast)							2. Date of De	aath Day	Year	3. Time of Death
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So Special Security Number So Special Security Number Security Securi								4b. City, T	own, or	Location of	of Death		4c. C	ounty of Death	h
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The Sales 100, County 100,				6.								8. Date of Bill (Month, Da Feb • 1	3, 19	27 Pen	nplace <i>(St</i> ate o <i>r Forei</i> untry) nsylvania
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Alexander King Alexander King Isa. Motimanth Name/Relationship (Type, Print) Frank J. Carr (Husband) 20a. Method of Disposition 10busia 20 Carra (Husband) 20b. Please of Disposition 11		plete	(Specify only	highest g	rade completed)	4or 5+)	(Give	kind of work DO NOT use	done d retired,	during mosi f)	t of work	ing	100. Kind	of Business/i	naustry
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Prank J. Carr (Husband) 529 Powell Drive, Annapolis, MD 21401		P			(Type, Print)		19b. Mailir	na Address (Street a					Town State Z	in Code)
Part Crematory 4-14-2006 Baltimore, MD															,,,
23a Part : Enter the distrate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause in Enter in Ente				ation 3	□Removal from S	20b. P	lace of Dispo emetery, crei	sition (Name natory or oth	e of ner place	e)		Date	20c. Loca	ation - City or T	Town, State
23a Part Lette the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Approximate memorial displaces of conditions of control or resulting in death) Due to (or as a consequence of): Due to (or as a conseque			`4 □ Donation 5 □ Ot	her (Spec	cify)									imore,	MD
IF FEMALE: 23c. Hy vs. outcome of pregnant resulting in death) Last			21. Signature of Fareral 9	vice Lic	ensee		22	Hardes 12 Ric	Addres Sty dge1	Fune i Fune i Ly Ave	ral 1 enue	Home, P , Annap	.A. olis,	MD 214	401
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## FEMALE: 23b. Was decedent pregnant in the past 12 moords? 1 1 1 1 1 1 1 1 1	Examiner		cause. Enter Underlying Cause (Disease or injury that initiated events	1			uence of):	_ Su	& C	· <u>c</u>		Peril	MY,		
25. Was case referred to medical examination of local light of light of local l	The same of the sa	ysician/Me	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No		1 ☐ Live bin 4 ☐ Pregna	th 2 ☐ Fetal nt at time of d	Ideath 3						23		•
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29a. Certifier (Check only one) 1		fication;	1 Natural 5 5 6 2 Accident ii	nvestigati Could not	on (Morth)	, Div Year) of Figury - At ho	Unkno Unkno	wn™	1 🗆 Y		6	Fell w	Street and I	walki	7 (20
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 10 0 6		Certi	4 Homicide		building	g, etc. (Specif)	ho	me				29 Pow	ell D	r. Anna	apolis, MD
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/10/06		edica	(Check only 2 Me	rtifying F dicel Ex	eminer: On the bas	is of examinat	wledge, death tion and/or in	occurred at restigation, in	t the tim n my op	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) ar date and pl	nd manner as a lace, and due t	stated. to the cause(s)
		Σ	29b. Signature and title of o	entitier							97		29d. Date :	signed (Month,	, Day, Year)
			30. Name and address of p	erson wh	o completed cause	of death (Item	23a) (Type,		1	7 36	- 1	0	1	1,010	N 5

DHMH 17 Rev 1/2001

Registrar

			1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	artment of Health and Martificate of Death	ental Hygier	000 10000
	Physicia	an	Decedent's Name (First, Middle, Last)			3. Time of Death
	/Medic	al	Clayton A. Davage 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4/9	106 12:05AM
	Examin	er	Prince George Hospital	Cheverly		Prince George
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Director		219-54-8226 TANK 2 F 54 Yrs. Usual Residence of Decedent		July 5, 1	951 Washington, DC.
	ryland how		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	8a-f s	Directo		Heights	140	1 ⊠Yes 2 □ No
	with t	i Dir	10e. Street and Number 7212 Willow Hill Drive	10f. Zip Code 20743		Citizen of What Country?
	death	Funerai		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F		14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the M. Jical Ex. cit er mant be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 No Specify:	, 110417	Specify: Black
21215-0036	2 hour	ted b	15 Decedent's Education 16a Dece	dent's Usual Occupation	16b.	Kind of Business/Industry
215	ithin 7.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of workir DO NOT use retired)		
N	iled wi Hygien ther th		12 Lett 17. Father's Name (First, Middle, Last)	er Carrier	(First, Middle, Maid	. S. Postal Service
auc	ld be f ental } ked ol ic ava	To Be	Russell Davage		Brooks	,
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show ther traumatic avant. Ite Model Examiner man be notified at			ng Address (Street and Number or Rura		
e, ≤	Health Health tem 27 thar tra		20a Method of Disposition 20b. Place of Dispo	Willow Hill Dr. C		Location - City or Town, State
altimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or othar ODCs.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place) tion cemetery4/18/2	c c	linton, MD.
a E	permit. F Departme Importar any injur			2. Name and Address of Facility	pe Funera 38 Marlbo	I Homes
<u> </u>	89 = 8		wa Allely	Fo	restville	<u>, Md. 2</u> 0747
			23a. Part1. Enter the distant. or complications that caused the death. Do not ent shock, or heart failure. المناطقة only one cause on each line.			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a	ENCEPHALOISI		
	Examiner .		11 120,2	ATTRY FAILUIL	C ⁼	
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events			
	execut n and ial-trar	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):	UN 14		
3760,	death certificate be executed to attending physician and ad for use as the burial-transit	icai	d			
39 ×	entifica ding ph	9	IF FEMALE: 23c. If yes, outcome of pregnancy			004 B.4. 44 F
Box	leath certific attending p	cian	in the past 12 months? 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
о. О	at the de by the a tached	Physician/M	9 Unknown			
Ś	The taw requires that the tee bas been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Onknown
Record	w require been si should I	eted			24a. Was an	24b. Were autopsy findings available
_	aician: The law certificate has b irector, page 2 s	Completed		,	autopsy performed′ 1 ☐ Yes 2 ☑	prior to completion of cause of death?
Vital		BeC	25. Was case referred to medical examiner?	26. Place of Death		40 13100 23110
	this ald	ို	1 Yes 2 No Hospital: 1 ☑ Inpatient 2 □ EP/Outpatier 27. Man + r of Death 28a. Date of Injury 28b. Time o		me 5 Residence 28d. Describe how in	6 □Other (Specify)
Division of	Attending F r death. ector: After by the funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at 2 Work? M 1 □ Yes 2 □ No	Edd. Describe flow in	july occurred
VISI		Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, tarm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Str	and Number or Rural Route Number, ate)
	ospital or hour: afte uneral Dir					()
	124 H	Medicai	29a. Certifier (Check only one) Check only one) Medicel Examiner: On the basis of examination and/or in and manner stated.			
	Within 2 To the complet	Me	29b. Signature and title of-certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
)	(10)		1 Bech	D0053703	, L	119106.
	20		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Al De Chois	arly M	021485
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TO THE VE	7	
	Regist	1 2	APR 1 3 2006 Men & 400	de		
DH	MH 17 Bay 1/2	1 2	APR 1 3 2006 See 4	W		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	laryland		artment of rtificate or			F	Reg. No.	6	3586
(S)	Physici	an	Decedent's Name (First, Middle, L.	,						2. Date of Dea Month	Day	Yeer	3. Time of Death
	/Medi	cal	Harry W: 4a. Facility Name (If not institution, gi	inslow DeL			4b. City, Town,	ar Logation	of Dooth	April	-	y of Death	1:05 P M
7	Examir	ier	2793 Autumn Chase		,				or Death				
	Funeral	-			ge (In yrs. las	st birthday)	Annaı If Under 1 Yea	r If Under		8. Date of Birt	h	Arun d 9. Birthp	e L lace (State or Foreign
1	Director		267-22-0547	1 M 2 □ F	78	Yrs.	Months Day	s Hours	Min.	Nov. 2	3, 1927	Nor	lace (State or Foreign fry) th Carolina
	pus *		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	ncation					11	0d. Inside City Limits
	e Maryla a-f sho	ctor	Maryland Anne A	rundel	,			apolis					1 ☐ Yes 2 No
	h with the	ai Dire	10e. Street and Number 2793 Autumn Chas	e Run			10f. Zip Code	2140	1		10g. Citizen of U	What Coun	try?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Amed Forces 1 17 Yes 2 11 Yes, Give Year or Dates:	2		Was Decedent of If Yes, specify Cu			ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americ ick, White, i	
2-00	72 hour naturat	ted b	15. Decedent's f	ducation	133	16a. Dece	dent's Usual Occ	upation	et of work	ung	16b. Kind of E	Business/Inc	lustry
121	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 2	5+)		kind of work don DO NOT use retii eutenant			ing .	U.S.	Air Fo	orce
Maryland 21215-0036	ould be filed Mental Hyginarked other	To Be Co	17. Father's Name (First, Middle, Las Howard DeLancey					18. Mothe	er's Nam	e (First, Middle, Leagan			
	and 2 shoul ealth and Mo n 27 ie marl ier traumati		19a. Informant's Name/Relationship Pam Jenkins/dau	(Type, Print) ghter			ng Address (Stree B Autumn						^{Code)} nd 21401
Baltimore,	Pages 1 an nent of Heal int: It Item 2 iry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		cen	m <i>eter</i> y, crei	sition (Name of matory or other po n Nat. Co	emeter		Date 24/2006	20c. Location Arling		wn, State Virginia
Balti	permit. Pages : Department of H Important: it its any injury or ot		21. Signature of Funeral Service Lice	ensee			Name and Add				_		1 Home MD 21401
8760,	Physician /Medical Examiner The print-transit printing the printing t	ai Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. PNE Due to (or a: b. Due to (or a:	Ine. UMO s a conseque PSIS s a conseque	NIA ance of): IME	er the mode of d				rest,		Approximate Interval Between Onset and Death
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ds, P.O.	law requires that the de as been signed by the a 2 should be detached i	ρ	Part II. Other significant conditions	contributing to death	but not result	ting in the u	nderlying cause o	given in Part I		23e. Did to			e cause of death?
Records,	0 4 0	Completed								24a. Was a autop perfor	med?	death?	psy findings available appletion of cause of 2 2 30
Vital		0	25. Was case referred to medical					26. Place	of Deat	h (Check only or	·	10103	2.50.0
Ţ <	d is	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpati	ient 2 🗆 El	R/Outpatier	it 3 DOA	ther: 4 🗆 Nu	ursing Ho	me 5 Resid	ence 6 Ott	ner (Specify)
Division of	ding After fune	ertification:	27. Manner of Death XXNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	-		28b. Time o Injury	M 1[ŢYes 2□	No	28d. Describe h			
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O	4 Homicide determined	building, e	tc. (Specify)		eet, factory, office			City or Tow	n, State)		Route Number,
	he Host in 24 hot he Fune pletely fi	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the best miner: On the basis and manner s	of examinatio	ledge, deatl on and/or in	n occurred at the vestigation, in my	time, date an opinion, dea	nd place, ath occurr	and due to the d red at the time, d	ause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
)	To the within 2 To the Complet	W	29b. Signature and title of certifier	Stones	2/ /	un.	_	nse number	23		29d. Date signe		Day, Year)
			30. Name and address of person who		1	23a) (Type,	DC Print) Defense 1	Gi (Macu	4 E	ule 200	Anna	polis	21401
7	Sta	ite	31. Date filed (Month, Day, Year)		trar's Signatu	ге			7				

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)		С	partment of F ertificate of			eg. No.			
nysicia Medica	ai	Franke	DiPiet	ro			April 1	1, 2006		3. Time of Death 2:13P	
xamine neral ector		4a. Facility Name (If not institution, give s Anne Arundel Medi 5. Social Security Number 219-42-4622 1X	cal Cente	e (In yrs. last birthde	Annapo	r Location of Death Lis If Under 24 Hrs. Hours Min.		Anne	Arun	del place (State or Foreight) Carolin	
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or		1	1107. 13	, 1344		10d. Inside City Limi	
a Kellin	Director	Maryland Anne Aru	ndel	Crownsvi	lle					1 ☐ Yes 2 💢 N	
then	Dire	10e. Street and Number 1454 Fairfield Loc	on Poad		10f. Zip Code 21032			0g. Citizen of \ USA	What Cour	ntry?	
3	by Fur		12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	1963- 1965	3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNo cedent's Usual Occup ive kind of work done	Specify: ation during most of work	pecify Yes or No- o Rican, etc.)	14. Rac	ck, White,	ite	
A SE	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5)+)	in the section of the	•		Genera	.1 Coi	ntractor	
	Be	17. Father's Name (First, Middle, Last) Nicholas John DiPie	etro				ne (First, Middle, M ene Denni		10)		
any Injury or other treumatic ev	- 6	19a. Informant's Name/Relationship (Typ. Nicholas J. DiPiet: 20a. Method of Disposition 1 ∑Burial 2 □ Cremation 3 □R. 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service License	ro/Father	709 20b. Place of Dis cometery, c Resurre	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shore Dr. Box 12 Edgewater, MD. 21037 Sposition (Name of trematory or other place) ection Cemetery 4/15/06 Clinton, MD. 22. Name and Address of Facility Geo. P. Kalas Funeral Hom 2973 Solomons Island Rd. Edgewater, MD. 210					own, State	
cr use as the burial-transit	=	23a. Port1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, Juacing to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	enter the mode of dyin	g, such as cardiac	or respiratory arre	ist,		Approximate Interval Between Onset and Death	
ached for use a	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Dat Mor	e of delive	ny Day Year	
e i	2	Parf II. Other significant conditions conf	tributing to death bu	ut not resulting in the	underlying cause give	en in Part I.			ibute to th	e cause of death?	
r. page z silouid	-						24a. Was an autopsy perform 1 Yes 2	ed?	rior to con eath?	osy findings availab npletion of cause of 2000	
	0 🕝	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	nt 2 X R/Outpati	ient 3 DOA Othe		h <i>Check only on</i> e ome 5 ☐ Resider		er (Specify	<i>'</i>)	
completely filled in by the funeral director.											
letely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
р р		29b. Signature and title of certifier		number	29	d. Date signed	(Month, L	Dey, Year)			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 7,2006 Physician June Louise Edmonds 10:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, 5/10/18 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Year) 578-12-9724 New London Conn Director Usual Residence of Deceden 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes X No Directo D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 K St., N.W. # 432 20001 U.S.A. 238 death Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-1 ☐ Yes XXX No þ Specify 3 ☐ Widowed 4 ☑ Divorced "natural", American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Drug Enforcement Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Lab Technician Administration 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental H 27 is marked of traumatic sver Pages 1 and 2 should be James W. Potts Mabel H. Parkhurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is sny injury or other trau Jean M. Jackson/Daughter 7602 Bethal Dr., District Heights, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/13/06 Harmony Mem. Park Landover, Maryland 21. Signature of Funeral Service Licensee H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 any W. 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Sepsis /Medical Due to (or as a consequence of) Examiner MRSA Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes Mellitus, Type II physician a s the burial-Box 68760. Physician/Medical Lumbar Epidural Abscess Drained attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de. 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown Records, P. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Large Sacral Decubitus Ulcer been si should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Rheumatoid Arthritis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate Colon Cancer 2 No Division of Vital 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification; To 2 ER/OutpatienI 3 DOA sitis After this funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: , 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Vithin 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier yletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) D41752 April 8,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1500 Forest Glen Road, Silver Spring, Md. 20910 Bergit Schoellman, 31. Date filed (Month, Day, Year) APR 1 3 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

	**		For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of He		lental Hygie	2000	13590
	Physici /Medi	an	1. Decedent's Name (First, Middle, La John	М.	Flood			2. Date of Death	Day 2006	
	Examir	ier	4a. Facility Name (If not institution, gir Doctors Communi	ty Hospita	al	4b. City, Town, or Lanha	m	,	4c. County of Deat Prince	George
7. 	Funeral Director			Sex 7. A(1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ge (In yrs. last birthday, 66 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Sept. 20,	9. Birt Co 1939 Was	hplace (State or Foreign untry) h DC.
	Maryland	Į to	10a. State 10b. County	George	10c. City, Town or L	ocation estville			-	10d. Inside City Limits XXYes 2 □ No
	h with the 23a or 28s	ai Direc	Maryland Prince 10e. Street and Number 6503 Hansford S	treet		10f. Zip Code	20747	10g.	Citizen of What Co United S	
980	772 hours after death with the Maryland "natural", or lieme 23s or 28s-1 show calcal Expr. inner, and by retilling at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marned 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	1061	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B	
21215-0036	within ene. then	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th		(Give	edent's Usual Occupa e kind of work done di DO NOT use retired) Teache	uring most of work	ing 16l	b. Kind of Business/	•
Maryland 2	be file tat Hys d othe	To Be C	17. Father's Name (First, Middle, Last John W. Flood)				e (First, Middle, Mai zabeth Joi		
	4430	l iš	19a. Informant's Name/Relationship Zenobia Flood/Spc			ing Address (Street a B Hansford				
Baltimore,	permit. Pages 1 and Department of Heali Important: If itam 2 any injury or other once.		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			osition (Name of matory or other place)		c. Location - City or Clinton,	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Lice	nsee C	04/2	2. Name and Address	s of Facility Posts	ope Funera 38 Marlbo prestville	al Homes oro Pike e, Md. 20	0747
8760,	Physician / Medical Examiner Physician and	dical Examiner	23a. Part1. Enter the disease or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as b. Cous to Yas c.	- 1	chojmes	nm) in.			Approximate Interval Between Onset and Death Troopfur It II
P.O. Box 6	death certiff e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 ☐Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
-	w requires that the been signed by th should be detache	Ď	Part II. Other significant conditions Auto Imp	contributing to death to		inderlying cause give	n in Part I.			the cause of death?
of Vital Records	The law ate has b page 2 s	Completed	Ische mie	Bourel Hegentos	ma			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Zi.		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ☐ ER/Outpatie	Otho		n <i>Check only one</i> l	e 6 ⊡Other (Spec	nitv)
Division of	ding h. After fune	ertification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			of 28c. Injury Work	at	28d. Describe how		,,
Divis	of the control of the	O	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of in	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	t and Number or Ru itate)	ral Route Number.
	o the Hospitel within 24 hours a To the Funerel Completely filled	ledical	(Check only 2 Medical Exa	nysician: To the best miner: On the basis of and manner st	of my knowledge, deat of examination and/or in ated.	vestigation, in my opi	inion, death occurr	ed at the time, date	and place, and due	to the cause(s)
1	Com	Σ	29b. Signature and title of certifier	vi n	7)	29c. License	number	29d.	Date signed (Month	
(Q/IVa		30. Name and address of person who	completed cause of	death (Item 23a) (Type, Penn. Ave			16.	4/3/06 un 7	
Section.	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 200	. negist	rar's Signature	ones vig	The IT IS	DELOGEO,	1111 20	01/2

DHMH 17 Rev 1/200

State

Registrar

APR 1 3 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vest **Physician** 3:30 рм April 2006 James W. Fav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Lutheran Village Westminster If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** ₩ M 2□F Months Director 147-07-3932 Oct 27, 1916 New Jersey 89 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28e-f shov 1 ¥Yes 2 □ No NJ Bergen Hillsdale Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Chadwick Cr 07642 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 N Yes 2 No 1942

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: naturel', 1945 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. NJ Motor Vehicle Elementary/Secondary (0-12) College (1-4or 5+) Managing Director Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental is marked Thomas Fay ၉ Julia Fay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 Is
any injury or other trau Wife 115 Chadwick Rd. Hillsdale, NJ 07642 Joyce Fay 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cem. 4/19/2006 Tenafly, NJ 21. Signature of Finance ral Service Licensee Pritts Furier all Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Due to as a consequence of): /Medical Examiner Due to (o) and consequenty of): Sequentially list conditions, if any, leading to immediate cause. Enter Under ind Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Advanced Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 27 NO certificate 1 Yes 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Natural Certification: Injury 5 Pending death. 1 ☐ Yes 2 ☐ No Accident investigation Director: 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 - Homicide hours after within 24 hours a To the Funerel D ertifying Physician: To the best of my knowle democcurred at the time, date and place, and due to the cause(s) and manner as stated.

| My call Examiner: Do the basis of examination in the investigation, in my opinion, death occurred at the time, date and place, and due to the content of th 29a. Certifier Medical (Check only one) the basis of examinal nd manner stated. Ir investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number WI 23a) (Type, Print) 30. Name and address of person who completed φ

Registrar

31. Date filed (Month,

Year)

32. Redistrar's Signa

Examiner Funeral Director with the Maryland rei', or itema 23a or 28a-f ehow Exartime must be notified at Director deeth v Funeral filed within 72 hours after 10 Baltimore, Maryland 21215-0036 þ "naturel" Completed other than "natur permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth ery injury or other traumatic event 900. Be **Physician**

The law requires that the death certificate be executed attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, the þ signed b peen has

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Da}Ž006 April 10, **Physician** 6:50 Hatfield Ford Lorraine /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Anne Arundel Edgewater 111 Southdown Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1 □ M 2 XF Yrs. August 28,1930 Canada 213–56–8535 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b, County 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Edgewater 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 111 Southdown Road 21037 USA Canada 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ena Foster Halket 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Thomas Ford-Husband 111 Southdown Rd., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) April 12, 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Edgewater, MD Kalas Crematory 21. Signature of Funeral Sepringe Licepsee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. Pam. Effer the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21037 Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Arteriosclerotic Cardiovascular Disease 1 day disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home See Residence 6 Other (Specify) 2 1 XYes 2 □ No 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the the e 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Dobin, M.D.
31. Date filed (Month, Day, Year) 20716 4175 N. Hanson Ct. #203, Bowie, MD State APR 1 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#10g,perFH, \$355.5/10/06 TT Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

			1 - State Ragistrar Amend Items 2	State of Ma 36,23a,P	tii,25,2	partment of F 28a-f per ertificate of	lealth and Death	6,067p97	gieņe 06 No.	6	13594
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
1	/Medic			Viola F	oster				15, 200		1500 M
	Examin	er	4a. Fecility Name (If not institution, give st	·	C	4b. City, Town, o			4c. County		
	Funeval		Calvert Manor Hea 5. Social Security Number 6. Sex		(In yrs. last birthd	ay) If Under 1 Year		rs. 8. Date of Bir	th	Ceci	lace (State or Foreign
	Funeral Director			M 2 🔀 F	91 Yrs	Months Days	Hours Mi	in. (Month, Da Jan. 2	y, Year) 3, 1915	Mary	yland
	p.		Usuel Residence of Decedent 10a, State 10b, County		10a City Tayla						Od Incide Challings
	show	7	_		10c. City, Town o					, 10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	tha M	Director	Maryland Cec 10e. Street and Number	11		Port De	posit		10g. Citizen of V	Vhat Coun	
	3a or		175 Jackson Park F	Road			21904		-	U.S.A	•
	death	Funerai	11. Marital Status	2. Was Decedent I	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin?	(Specify Yes or No	- 14. Race	e - America k, White, e	
21215-0036	within 72 hours after death with the Maryland nne than "natural", or Itams 23a or 28a-f show than Madical Eveniner meat be codified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ło	1 ☐ Yes 2 ☑ No	Specify:	arto ritoari, atc.,	Specify		hite
2-0	72 ho	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. De	ecedent's Usual Occup live kind of work done e. DO NOT use retired	nation during most of w	vorking	16b. Kind of Bu	siness/Inc	Justry
21	within iene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)		_		D	7	D : d
	ba filed wital Hygie id other t		Eleven Years 17. Father's Name (First, Middle, Last)			Homemake		lame (First, Middle,			Residence
Maryland		To Be	John Herm	an Jacks	on				et M. Su		
37	should ba and Mental Is markad o aumatic eve	F	19a. Informant's Name/Relationship (Typ	e, Print)	19b. M	ailing Address (Street	and Number or				Code)
	nd 2 ilth a 27 15 r tra		William E. Foster,	Sr. (Hu	sband) 17	5 Jackson	Park Ro	ad, Port	Deposit	, Mar	yland 21904
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery,	sposition (Name of crematory or other place		Date	20c. Location -	1	
tim	7 E E E		4 □ Donation 5 □ Other (Specify)21. Signafure of Funeral Service License		Hopewe	11 Cemeter 22. Name and Addre		/20/06	Port Dep	posit	, Maryland
Ba	Department	12	Mhomes h	7100500	M. 60	Lee A. Pat	terson			ne, P	.A.
п			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lir	the death. Do not ne.	enter the mode of dyir	ng, such as card	lac or espiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	ļγ	Immediate Cause (Final disease or condition resulting in death)	- Pelvi	c fra	ture	1				Swecks
	Examiner			1	a consequence of):		///	/ .	4 0		Que the
		Jer	Sequentially list conditions, if any, leading to immediate the conditions of injury.		consequence of):		44	ANTED BY MEDICALE	KAMINEN		ONGKINS
	cuted nd ransit	Examine	that initiated events				U	ONED BY WEDIG			
50,	icate be exacuted physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequence of):		-TIFICATION APP				
68760,	ficate be exacute physician and s the burial-trans	edical	d.				Ku				
Box (eath certifi attending for use as		IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome	of pregnancy	a 🗆 5			23d. Date	e of delive	ory
	law requiras that the death certii as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☑No	4 Pregnant at	2 ☐ Fetal death time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Mor	ıth	Day Year
P.0	at the de I by the stached	Phys	9 🗆 Unknown					00 Div		/h. A. A. Ab	
	ras tha signed be det	by	Part II. Dther significant conditions cont	nbuting to death bi		e underlying cause giv	en in Part I.				ne cause of death? ably 4 ∐Unknown
0.00	w require been sign	etec	1 The It Diago	elex 11 W II	1112						
of Vital Records,	The law ate has page 2 s	Completed	Hyperten 575	n				24a. Was autor perfo	osy ormed?	rior to con leath?	psy findings available mpletion of cause of
a		e Co	25. Was case referred to medical	illution,	Lymphoma	l	26 Place of P	1 Tyes	2 1 No 1	Yes	2 No
\(\bar{\bar{\bar{\bar{\bar{\bar{\bar{	Physician: this certific ral director,	To Be	eyaminer?	ospital:	nt 2 ER/Outpa	tient 3 DOA Oth		Home 5 Resi		er (Specify	·)
	ding Phys		27. Manner of Death	28a. Date of Inju	ry 28b. Tim	e of 28c. Injur			how injury occurr		
ior	Attending or death. ector: After by the funer	atio	2 Accident 5 Pending investigation	03/28/2			Yes 🎾 No	Subject			
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm c. (Specify)	, street, factory, office		28f. Location (S	Street and Numbe vn, State)	or Rurai	I Route Number
	pital ours al		29a. Certifier 1 Cartifying Physi	at ho		eath occurred at the tir	= o data and pla	T			Pt.Deposit
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Madical Examinations)	ar: On the basis of and manner sta	examination and/o	r investigation, in my o	ppinion, death oc	ccurred at the time,	date and place, a	ind due to	the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1 1		29c. Licens	se number		29d. Date signed	(Month, I	Day, Year)
)			Jungly K. Wei	wher of	MP	Do	04437	3	4/17	/20X	36
	10		30. Name and address of person who con				D:	C		77.0=	
			Joseph K. Weidner, 31. Date filed (Month, Day, Year)	Jr., MD	, LUL COL ar's Signature	onial Way,	Kising	Sun, Mar	yland 2	21911	
	Sta Regist، ہ		APR 1 8 2006	de la la	ar's Signature	,					
			111 11 11 W PACA	W-65-0-0							

Please Type or Print in Black Indelible Ink

Steward Wesley Fr	1-	State of Maryland / Department of Health and Mer Certificate of Death Decedent's Name (First, Middle, Last)								ntal Hygiene Reg No. 2006 13595				
Physician/ Medical Examine	1.	Decedent's Name (First	st, Middle,Las EWARD	WESLEY I	FRAZIER					2. Date of Dea Month April 17, 2			3. Time of Death 1444 hrs	
and the same of th	4:	a. Facility Name (if not in Washington Cou			nber)			Town, or Locat erstown	ion of Death		4c. County o Washing		- · · · · · · · · · · · · · · · · · · ·	
Funeral Director		Social Security Number 215-50-9530) ₁ X	M 2 F	7. Age (In yrs. I	last birthday) Yı	Month		Jnder 24Hrs ours Min		rth(MM/DD/YYYY) 1962	9. Birth Foreign Coul	MARY LAND ntry)	
faryland 28a-f show any 1 at once.	10	sual Residence of Dece Da. State 10b. (B)	County ERKELE	Y	10c. City,	RTINSB		0					10d. Inside City Limits 1 Yes - 2 No	
the Maryland 3a or 28a-f sh otified at once Director		26 PRICE	DRIVE	APT. 21	3		10f. Zip	5401		1	0g Citizen of Wh	JSA	ry?	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f shratic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	تاه	Widowed 4		Armed For 1 Yes If Yes, Give Year or Dates:	2 No	1	Yes, speci	fy Cuban, Mex No <i>sp</i> e	ican, Puerto		White Specify:	BLA		
5-0036 ed within 72 hours lygiene other than "natur the Medical Exam Completed 1		15. Decedent's Education Elementary/Secondary	/ (0-12)	College (1-		during	nost of wo	Occupation (Grking life, DO N	OM)	ired)	HOSPITA	A L	dustry	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica To Be Compile		7. Father's Name (First, STEWARD H	. FRAZ	IER					BETTY	E CANNAI				
	19	STEWARD H.	elationship (T FRAZI	ER/FATH	ER	19b. Maili 10638	Address HICK	(Street and ORY CREST	Number or I LANE,	Rural Route Nur COLUMBIA	mber, City or Town	, State,	Zip Code)	
20a. Method of Disposition 20b. Place of Disposition (Nan 20c. Place of Disposition (Nan 20									22,	I ^{Date} 2006		•	JRG, W	
Balt permit Depart Impor injury		hackon	K.B	own						NSBOXG,82		KING	ST.,	
Physician /Medical xaminer	Ir	3a. Part I. Enter the dise failure. List only one nmediate Cause (Final or r condition resulting in c	e cause on ea disease a.	ich line. Multiple Inju	ries		the mode	of dying, such	as cardiac c	or respiratory arr	rest, shock, or hea	rt	Approximate Interval Between Onset and Death	
	s	equentially list condition any, leading to immedia	ns, b.	Due to (or as a of	Ì									
red Insit	C (1	ause. Enter Underlying Disease or injury that in vents resulting in death	Cause c.	Due to (or as a								-		
and and	-	UNPENDED	, d.	AMENDED										
760, Teate be expression the burial		FEMALE:	ant in the	23c. If yes, o	utcome of preg	P					23d Date of			
). Box 6876(the death certificate by the attending physiched for use as the b Physician/Me	1	past 12 months? Yes 2 No 9	Unknowr	9 Unknov	nt at time of de vn	eath 5 (etal death Other (Spe	cify)	topic pregna		Month	Da		
ires that the signed by the detache	2	art II. Other significant	t conditions	contributing to	death but not r	esulting in the	underlying	g cause given i	n Part I.		obacco use contrib s 2 No 3		ne cause of death?	
cords aw requires been 2 should										24a. Was autop perfo 1 Yes	rmed? de		opsy findings available mpletion of cause of	
Vital Rechysician: The hysician: The lift is certificate lift director, page	^{2:}	5. Was case referred to examiner? 1 ✓ Yes 2	-	lospital: 1 In	patient 2 🗸	ER/Outpatier		26.Place of De OOA Other		only one)	Residence 6	Other:		
ion of V ttending Ph death for: After to the funeral	2	7. Manner of Death 1 Natural 5	Pending Investigati	28a. Date of (Month) Apr 17, 2	f Injury Day Year) 006	28b. Time of 1343 hrs	Injury	28c. Injury at V			how injury occurre r in collision	ed		
Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the funeral edical Certification:		Suicide 6 Homicide Gertifier	Could not determine	d (Specify)	of Injury - At h	d / Highwa	у			or Town, S Interstate 7	State) 0 at Mile Mark	er 38,	Boonsboro, MD	
To the Hospital within 24 hours To the Funeral completely filled	0	ne) 2 Medi	cal Examine		examination a		ation, in my	opinion, deat	h occurred a		se(s) and manner and du	ue to the	cause(s)	
× ×	2	9b. Signature and title o	or certifier	. HD			290	O.C.M.E.	ber		April 18, 20		h, Day, Year)	
6	3	0. Name and address of Ana Rubio MD.		completed cause		123a) 111 Penn	Street, E	Baltimore, N	MD 2120	1	1			
State Registra	e ³	1 Date filed (Month Qu		0.6 32 Reg	istrar's Signat		de							

			1 - For State Registrar	State of M				of He	alth a		ental Hyg	/11	0.6	13596	
	200		Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)		Cel	lincate	OID	calli		2. Date of Dea	Reg. No.		3. Time of Death	
	Physici		Arthur Goodma								Month April	Day 11	Year 2006	14:54 P	И
	/Medic		4a. Facility Name (If not institution, give		r)		4b. City, T	own, or Lo	ocation of	f Death	претт		ounty of Death		
	EXG.		Southern Mary	land Hosp	pital				Clin			I	rince	George's	
	Funeral		5. Social Security Number 6. So	9x 7. A XM 2□F	-	last birthday)	If Under 1 Months		If Under 2 Hours	Min.	8. Date of Birt (Month, Day	y, Year)		place (State or Foreig intry)	
190	Director		225-28-2116 Usual Residence of Decedent		86	Yrs.					Oct. 7,	1919	Nor	th Carolin	ıa
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limit	s
	Mary	ţō	Maryland Prince (eorge's				Clin	ton					1⊠Yes 2□N	5
	th the	Director	10e. Street and Number				10f. Zip 0					10g. Citize	n of What Cou	intry?	
	23a c	raiD	7600 Huntsman	Ct.					2073				Inited		
	tams	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13.	Was Decede f Yes, specif	ent of Hisp fy Cuban,	Mexican,	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	. 14	. Race - Amer Black, White		
36	rs afte	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 D If Yes, Give Year or Dates:	_		1 ☐ Yes 2	X No	Specify:			S	pecify: B	lack	
8	thon sture	ed	15. Decedent's Ed	lucation	·	16a. Dece	dent's Usual	Occupati	on			16b. Kind	of Business/l	ndustry	
215	hin 72 on "nu Meu	Completed	(Specify only highest gra	de completed) College (1-4or	r 5+)	(Give	kind of work DO NOT use	done dui retired)	ring most	of workii	ng				
21	giene giene	DO.	6th		- /		Far	mer/	Roofe	er			Priva	te	
nd	be filed within 72 hours after death with the Maryland tal Hygiene id other then "natural", or Itams 23a or 28a-f ehow event, the Maulical Exontina frund by notified a	Be	17. Father's Name (First, Middle, Last)					1	8. Mother	r's Name	(First, Middle,		The state of the s		
<u>Y</u> a	ould Men Marke	ဥ	Arthur Goo			401 14 15		(2)			Bess I Route Numbe	ie Sm		. 0.41	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Items 23s or 28s-f show apprigning or other treumatic event, the Mauteal Examiner must be notified at an angree.		19a. Informant's Name/Relationship (19a. Mildred Debrew/D								inton,		20735	p C0 09)	
	Heal Heal tem 2		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name	e of			ate		tion - City or T	own, State	_
Baltimore,	ages ent of ht; if i		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		8	semetery, cred Marv [†] s			1	4/15	/2006	На	lifax	Co., NC	
ä	permit. Departm Importal eny Inju		21. Signature of Funeral Service Licen				2. Name and				tewart				
m	Depa Impo eny Is		John J. S.	avoit I	16	ļ	400	1 Bei	nning	g Rd	., N.E.	Wash	., DC	20019	
П			23a. Part1. EAter the disease, or company shock, or heart failure. List only	plications that cause one cause on each	ed the deal	th. Do not ent	er the mode	of dying,	such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a Ve	out	newla	arz	6	an	1/10	= tec	>		Onset and Death	
30	/Medical Examiner		resulting in death)	Due to (or a				1	11		. 0	. 1			
		20	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consec	Hence of):	rger	hus	= 4	rean	1 13	40	no		
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C	00.00	10011	. 1	Lax	-0 4	\	015=	200	>		
ó	le be executed ysician and e burial-transit	Еха	resulting in death) Last	Due to (or a	is a consec	quence of):	7	7-01	-00	7					
3760,		icai	(d											
89 ×	entifica ing ph e as t	Med	IF FEMALE:									0.			
Вох	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Feta	al death 3	Ectopic pre					23	 d. Date of deline Month 	легу Day Year	
o.	he de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time or t	18ath 50	_ Other (spe	CIIY)							
<u>α</u>	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Ph	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	nderlying ca	use given	in Part I.		23e. Did to	obacco use	contribute to	the cause of death?	
of Vital Records,	quires in sign										1 🗆 Y	/es 2□	No 3□Pro	bably 4 Unknow	n
000	aw requir s been si 2 should (plet									24a. Was		24b. Were aut	opsy findings availab ompletion of cause of	le
Ä	The I	Completed									perfor	rmed2/	death? 1 ☐ Yes		
/ita	cien: ertifica	Be	25. Was case referred to medical examiner?								(Check only o				
5	Physicien: this certific ral director,	ို	1 Ves 2 No			ER/Outpatier		A Other:	4 🗆 Nui		ne 5 □ Resid			ify)	
uc	sing After fune	ion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	Day Year)	28b. Time o Injury	M 20	Ic, Injury a Work? 1 □ Ye	at es 2 □ N		28d. Describe h	iow injury i	occurred		
Division	l or Attending after death. Director: After I in by the fune	fica	3 Suicide 6 Could not b	e 28e. Place of I	njury - At h	ome, farm, sti							Number or Ru	ral Route Number,	
Ö	E 5 4 6	Certification;	4 Homicide	building, e	etc. (<i>Speci</i>	(Y)					City or Tow	vn, State)			
	To the Hospital or Attent within 24 hours after death to the Funerel Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Ph (Check only 2 Medical Exert	ysician: To the bes niner: On the basis and manners	of examina	owledge, deat ation and/or in	h occurred a vestigation,	it the time in my opir	, date and nion, deat	d place, a	and due to the ded at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)	
	within To the comple	Me	29b. Signature and title of certifier	/_			29c.	License r	number				signed (Month		_
)	(4)		MA	80				041	1580			4-	13.0	6	
	Uge		30. Name and address of person who Scott Ke1	completed cause of		m 23a) (Type,		d., (Clint	ton.	MD 20	735		-	
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 7 2006		strar's Sign							-			

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Environment and Provided Sections of Community Engine and American Sections of Community Engine (Community Engine) Decordor's Community Number				Vance Gib	nson.								Coril	4 4 7 -	- 1	9:10A M
Social Security Number Security Security Number Security Num			See at			e street and nu	mber)		4b. City,	Fown, or	Location of	of Death	1	-	-	
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Continued of Accounts Continued of Accounts Continued of Continu													(Month, Day	v. Year)	9. Birthpl Count	ace (State or Foreigr ry)
ALLEH GLIDSON Wife 198. Mailing Address (Sheward and Number or Putal Robers Number, Coty or Town, State, Zip Code) 104. Joy Cecton, Wife, Joy Code, State, Zip Code) 104. Mailing Address (Sheward and Number or Putal Robers Number, Coty or Town, State, Zip Code) 104. Joy Cecton, Wife, Joy Code, John State, Zip Code) 105. Mailing Address (Sheward and Number or Putal Robers Number, Coty or Town, State, Zip Code) 104. Joy Cecton, Wife, Joy Code, Joy C	65°	ector					/6						04-09-	30	SC	
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	23a o ust be	Dia	215 Jefferson Ave	•			2541	4			U	.S.A.		
396	72 hours after death with the Maryland natural; or items 23a or 28a-f show lical Examinar rual be nutilied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1	Was Decedent of f Yes, specify Co 1 ☐ Yes 2X N	uban, Mexican	n, Puerto Ri	ify Yes or No ican, etc.)	-	14. Race - Americ Black, White, Specify: whi	etc.	
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	s 1 and f Health Item 27 other to		Karla Gainey-dau 20a. Method of Disposition		20b. PI	ace of Dispo	fferson sition (Name of natory or other p		Cnari		-	7 25414 ocation - City or To	own, State	
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Baltimore,	permit. Page Department of Important: if sny injury or once.		21. Signature of Funeral Service Licen	11			. Name and Add		FOL			Funera1		
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	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	iencs of).			-					
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_	ER		30. Name and address of person who a Michael Beran	1 730.	eath (Item	23a) (Type, altim	print) are Blu	4 107)	Colle	ge la	such mi)	20740	
Y	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2006	32. Registr	ar's Signat	Loss de	i v							

Physici		1. Decedent's Name (First, Middle, Last)			artment of 8a-f per rtificate o		2. Date of De		3. Time of Deat
/Medi		MARY		GR	oss		April	11. 20	Year 06 12:25 A
Examir		4a. Facility Name (If not institution, give s. Prince Georges Hosp			4b. City, Town Cheve	, or Location of De	ath	4c. County Princ	
Funeral Director		230-00-0307	7. Age (In yrs	. last birthday) 47 Yrs.	If Under 1 Year Months Day			rth ay, Year) /58	9. Birthplace (State or Ford Country) Virginia
r 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		ity, Town or Lo	ocation				10d. Inside City Lim 1 X Yes 2 □
or 28	Director	10e. Street and Number			10f. Zip Code	•		10g. Citizen of V	Vhat Country?
natural', or Itema 23a or 28a-f show deal Examiner must be notified at	by Funerai	8948 Continental 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Place 2. Was Decedent Ever in the Armed Forces? 1		Was Decedent of Yes, specify Co	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		A e - American Indian, ck, White, etc. r: Black
- 64	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	DO NOT use reti	ne during most of v ired)			usiness/Industry
ther int,	Cor	12 17. Father's Name (First, Middle, Last)		Pro	operty	Technici	an Iame <i>(First, Middle</i>		Private
	To Be	Leroy	Bell			Mab	le		Jones
= 2 =		19a. Informant's Name/Relationship (Typ James C. Gross (Hu					Rural Route Numb		
nt: If		20a. Method of Disposition 1 Burial 2 □ Cremation 3 Beautiful Control of Control	emoval from State	cemetery, crer	sition (Name of natory or other p	, I	Date 23/2006	20c. Location -	City or Town, State
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xaminer	<u>_</u>	1	Bonur.	110			// //		
physicien and the burial-transit	dical Examiner	Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consec	TRY	FAREN	CERTIFICATION	APPROVED BY M	NER NER	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of I	Maryland	i / Depa <i>Cer</i>	artment <i>tificate</i>	of H	ealth an Death		Re	g. No.)6	13600
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las Mary Grar	1GC			4h Cihi T	Our of	Location of D	(Date of Deat Month		2006	3. Time of Death 4. /4 AM
	Examin	er	4a. Facility Name (If not institution, give		er)		Takon			/eatii		Montg		
	Funeral Director	!	Washington Advertist 5. Social Security Number 6. S 579–28–4334		Age (In yrs. la	ast birthday) Yrs.	If Under		If Under 24	Hrs. 8. Min. 1.	Date of Birth (Month, Day, 2/10/192	Year)	9. Birthp	place (State or Foreign htry) h Carolina
		l ⊩	Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation							10d. Inside City Limits
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th the	or 28a	lrec	10e. Street and Number				10f. Zip				1	0g. Citizen of	What Cou SA	ntry?
M Hai	23a	rai	401 Dovovan Way	12. Was Decede	ent Ever in II	S 13)774 ent of H	ispanic Origin	n? (Specify	Yes or No-	14. Rac	ce - Ameri	can Indian,
	points: regge 1 and 20 to 20 t	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Force 1 Tes Z If Yes, Give Year or Date	es? X∏No		ff Yes, spec 1 ☐ Yes 2	rty Cuba	Specify:	Puènto Rica	an, etc.)		ck, White, fy: Bla	
72 00	netur	Completed	15. Decedent's E (Specify only highest gra	ducation de completed)		(Give	dent's Usua kind of wor DO NOT us	k done o	during most o	f working		16b. Kind of B	Business/Ir	ndustry
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Delia be block	lental Hygiked other	To Be C	17. Father's Name (First, Middle, Last Willie Bryant)					Eva l	Hillia	rd	Maiden Sumai		
S. Cha	and N is man		19a. Informant's Name/Relationship									r, City or Town		p Code)
100	ther tr		Paulette G. Mills - I	augnter	20b. P	lace of Disp	osition (Nan	ne of	!	Date		yland 2 20c. Location		own, State
0000	t: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			emetery, cre poln Ma				/08/20	06	Suitlan	d, Mar	yland
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0.0	hysician be executed by sician or the state of the state	dical Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a		rence of):	رگرد		PRO V	KES	, n.A			Onset and Death
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	The law requires that the death certificate be executed ate has been signed by the ellending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta ant at time of d	I death 3	□Ectopic pi □ Other (sc		у				eate of deli	very Day Year
	ures men signed by Id be deta	₽	Part II. Other significant conditions	contributing to de		culting in the		ause gr	ven in Part I.	_		obacco use co ⁄es 2 □ No	ntribute to 3 □ Pro	the cause of death?
	ine iaw require sate has been signage 2 should t	Completed	2652	15						_			prior to death?	topsy findings availat completion of cause of 2 No
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**	To the Hospital or Attending Prysicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, i	Certification;	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	on be 28e. Pface	of Injury · At h	Injury ome, farm, s	М]Yes 2□N		f. Location (S City or Tox		nber or Ru	ural Route Number,
	To the Hospital within 24 hours of the Funeral completely filled	Medical C	29a. Certifier To Certifying (Check only one)	Physician: To the aminer: On the ba	isis of examina	owledge, dea ation and/or	ath occurred investigation	at the t	ime, date and opinion, death	d place, an	d due to the at the time,	cause(s) and r date and place	manner as e, and due	stated. to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier				29	c. Licen	se number			29d. Date sign		
			Ivolda					1 &	992			04/6	12/2	006
	(10)		30. Name and address of person who	MO 7			e, Print)	AX	包、和"	30,	TAI	om A m D	GAL	2/2
	Si	tate	31. Date filed (Month, Day, Year)		egistrar's Sign		A.						Č1	

NARCISCO GONZALES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#23a Per Phy. 4/11/06 For AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Narciso Gonzales APRII 2006 /Medical 9:03 a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year) Oct. 29, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours **XX**M 2□ F 82 Yrs. Director 1923 Philippines 224-52-8156 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or items 23e or 28e-f show 1 ☐ Yes 2 📆 💢 Ø Director MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 421 Cedar Grove Road 21037 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? NTYes 2 ☐ No ITYes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or item any injury or other treumatic event, the Medical Exercities. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White þ Widowed 4 ☐ Divorced Year or Dates: 1945-65 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Enlisted U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Domingo Yap Fortunata Gonzales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Gonzales (Daughter) 421 Cedar Grove Rd., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 3-25-2006 Arlington Nat. Cem. Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lailure Physician /Medical Due to (or as a consequence of): **Examiner** Aspiration Pneumonia Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) of Examine The law requires that the death certificate be executed burial-tran to (of as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 2 or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: npatient he of Injury ို 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) erel Director: After th filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 25230 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) DAVID ALLEN MARYS HOSPITAL PO BOX 527 LEONARDTOWN MD 31. Date filed (Month, Day, Year) 32. Rafistrar's Signature State APR 1 2 2006 Registrar

			1 - For State Registrar	State of Mary	land / Depa			Mental Hyg	_	6	1360	32
	5 29		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		.,	3. Time of	Death
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	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Towr	, or Location of Death		4c. County)	
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9	d 2 should be filed within the and Mental Hygiene. 7 Is marked other then treumatic event, Italia	-	19a. Informant's Name/Relationship (7	уре, Print)Husbai			et and Number or Run	al Route Numbe				
	サード		Harry E. Goodr	ich Sr./	P.O.	Box 1	77 Str	eet, M	arylar	ıd	21154	
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	×2		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	death. Do not ent	er the mode of o	tying, such as cardiac	or respiratory arr	est,		Approximate Interval Bets	ө
`	Physician		Immediate Cause (Final disease or condition				edema				Onset and (Death
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Ø 3	death certificat e attending phy d for use as the	Mec	IF FEMALE:									
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$\frac{1}{2}$. 0 00	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)			1010	101	Day 1	641
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چ کے۔		o u	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	V	Vork? ☐ Yes 2 ☐ No	28d. Describe h	ow injury occur	өа		
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$\nabla \hat{z}$	2 # # E	Certification:	4 Homicide determined	building, etc. (S	pecify)	eer, raciory, one	e e	City or Town	n, State)	וטר זט וט	ai noute ivumi	Der.
(8)	pita urs eral		29a. Certifier 1/9 Certifying Phy	sician: To the best of my	v knowledne death	n occurred at the	time date and place	and due to the o	ause(s) and ma	nner as s	etated	
	To the Hosy within 24 ho To the Func completely f	edicai	(Check only 2 Medical Exam	iner: On the basis of exa and manner stated.	mination and/or in	vestigation, in m	y opinion, death occur	red at the time, d	ate and place,	and due t	o the cause(s))
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	, , , ,		1 Cusustu	(.		P	0063420	A	pril 23	,20	06	
, —	3		30. Name and address of person who d	completed cause of death	(Item 23a) (Type,	Print)	0 0	1 1			1	
, .	ン		ZubairSiddig	2500 Upp	er (hos	apaK	Dr. Be	1AiC.	MO	210	14	
	Sta Registr		31. Date filed (Month, Day, Year)	Registrars S	Signature App	all of			_		,	

		For State Registrar	ate of Marylan	•	tment of H ificate of I		d Mental	Hygien Reg. N	. 000	1360
Physicia		Decedent's Name (First, Middle, Last) Jamir	Gillespie				2. Date of Month	D:	ay Year 4 200	
/Medic Examin		Aa. Facility Name (If not institution, give street of ANINSULA SEGIONAL)	and number)	anse	4b. City, Town, or	Mishuy	eath	4	c. County of De	ath
Funeral Director		5. Social Security Number 6. Sex 120 M 2	7. Age (In yrs.		If Under 1 Year Months Days	Hours M	Hrs. 8. Date of (Mont. 55 4/1	of Birth h, <i>Day</i> , Ye <i>ai</i> 4/06	9. B Ma	irthplace (State or Fore Country) aryland
Maryland t-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomico	10c. City	y, Town or Loca	tion					10d. Inside City Lin
with the M 3a or 28a-f	il Director	10e. Street and Number 420 East Street			10f. Zip Code 2187.	5		10g. C	itizen of What (USA	Country?
I.X.I.D-UUSO within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show than "matural", or items 12a crotified at	by Funeral	1 XNever Married 2 Married 1 [as Decedent Ever in U. med Forces? Yes 2 X No Yes, Give aar or Dates:	lf \	as Decedent of H Yes, specify Cuba	ispanic Origin In, Mexican, P Specify:	? (Specify Yes ouerto Rican, etc	or No-	Black, Wh	nerican Indian, hite, etc. frican/ merican
BAITIMOFE, MATYIANG Z I Z I 3-UU. permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if Itsm 27 is marked other than "natural" any injury or other traumatic event, the Medical Exone.	Completed	15. Decedent's Education (Specify only highest grade complete comp	pleted) ollege (1-4or 5+)	(Give ki	nt's Usual Decup nd of work done of NOT use retired	during most of	working		Kind of Busines n/a	ss/Industry
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Mary od 2 shoulth and M 27 is mar traumati	-	19a. Informant's Nama/Relationship (Type, Pr Rasheedah Akram/mothe			Address (Street				or Town, State	, Zip Code)
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Physician /Medical Examiner physician and the prital-transit physician and the prital-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence to (or a conse	uence of):						
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dS, P	ρ	Part II. Other significant conditions contribut	ing to death but not res	ulting in the unc	erlying cause giv	en in Part I.	23e.		11	to the cause of death? Probably 4 □Unkno
DIVISION OF VITAL RECORDS, P.O. for Attending Physician: The law requires that the dafter death. Director: After this certificate has been signed by the lin by the funeral director, page 2 should be detached.	Completed						10		24b. Were prior t death 1 Yes	autopsy findings availa o completion of cause ? es 2 \(\square\) No
DIVISION OF VITAL HO To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	on: To Be	1 ☑ Natural 5 ☐ Pending	al: 1 X Inpatient 2 a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Oth	er: 4 □ Nursi y at k?	Death (Check ong Home 5 1 28d. Desc	Residence	6 Other (Spury occurred	oecify)
DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funersi Director: A completely filled in by the fi	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 280	e. Place of Injury - At h building, etc. <i>(Specif</i>	ome, farm, stree y)		Yes 2 ☐ No	28f. Local City o	tion (Street a or Town, Sta	and Number or te)	Rural Route Number,
ne Hospit n 24 hour ns Funst	Medical (: To the best of my kno on the basis of examina nd manner stated.							
To th within To th	W	29b. Signature and title of certifier	mes		29c. Licens	941 U		294. 0	ate signed (Mo	onth, Day, Year)
1/22	ate	30. Name and a ress of person who com N. Floyd 9 ray 2 31. Date filed (Month, Date, Year)	cause of death (Item	n 23a) (Type, P	Drick,	Sali	56075	Mel.	21504	4

	4		For State Registrar		State o	f Marylar		artmen rtificate					Re	g. No.	006	13604
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	/Medic	al	Terrence Hine									Marc	ch 3	T		9:44 p M
	Examin	er	4a. Facility Name (If not institution					, ,		Location of	of Death				County of Dea	
			Washington Adv	6. Sex		7. Age (In yrs	last hirthday)	If Under		Park If Under	24 Hrs.	8. Date	of Birth		Mont gon	thplace (State or Foreign
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2,460	. 4.		Usual Residence of Decedent													
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	B Ma	Director	D.C.				Washir	gton								1X Yes 2 □ No
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36	d within 72 hours atter death with the Maryland Jene. Ir then "natural", or itema 23a or 28a-f ehow If a Modical Esa oli sermant be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 □ Divorced	ned	. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 X No		Was Deced If Yes, spec 1 Yes				ecify Yes Rican, etc	or No- c.)		4. Race - Ame Black, Whi Specify: B	te, etc.
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<u> </u>	othe	Bec	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	First, M	liddle, N	Aaiden S	Sumame)	
/land	should be nd Mental marked c	To E	Kelly Dupree							Lucy						
Mary	s 1 and 2 should if Health and Men Item 27 ie marke other traumatic		19a. Informant's Name/Relations Harold Burke/B				412 Wash	ng Address F Str incto	eet,	N.E.	er or Rura	al Route N	Vumber,	City or	Town, State,	Zip Code)
อ์	tem tem tem	1	20a. Method of Disposition			20b.	Place of Dispo cemetery, crea	sition (Nari	ne of ther plac	e)		Date			ation - City or	
E	Pages nent of int: if it		1 🏋 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		noval from		antico				4-19	-200	6	Tri	angle,	Virginia
Baitimore,	permit. Pege Department of Important: if any in ury or gace.		21. Signature of Funeral Service	Licensee	Back	en cc.									eral Ho D.C. 20	ome, Inc. 0010
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	complica only one	cause on e	eaused the dea each line.		1		g, such as	cardiac (or respirat	tory arre	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	(a		(or as a conse										DED ELLOY
	Examine	_	Sequentially list conditions, if any, leading to immediate	b	5x	revid	0515									mhnero
7	si si	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	Due to	(or as a conse	quence oi).									y :
_	and I-tran	хап	that initiated events resulting in death) Last	c.	Due to	or as conse	quence of):			-				-		MENOU
8/60,	cate be executed oblysicien and the burial-transit	cai E			0	mom										akum
2	phys phys s the	dic		d)· /·e	24.001.										mercus
C. Box	The law requires that the death certiticate be executed te has been signed by the attending physicien and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230	1 Live t	tcome of pregr birth 2 Fet nant at time of own	al death 3[Ectopic pr Other (sp						2	3d. Date of de Month	elivery Day Year
a,	s that the de ned by the a a detached t	by Ph	Part II. Dther significant conditi	ons contr	buting to d	eath but not re	sulting in the u	nderlying c	ause give	en in Part 1	l.	23e.	Did tob	acco us	se contribute t	o the cause of death?
200	w requires been signi should be												1 🗆 Ye	s 2[]No 3□P	robably 4 XUnknown
Hecords,	The law re te has bee	Completed										24a.	Was ar autops perform	y	24b. Were a prior to death?	utopsy findings available completion of cause of
Vital H	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medica examiner?	ıl						26. Place	e of Death	h (Check		• •		
	nysic nis ce	2	1 Mg Yes 2 □ No	Ho	spital: 1 🔲	Inpatient 2	ER/Outpatie	nt 3 DC	Othe	er: 4□Ni	ursing Ho	me 5	Reside	nce 6	☐Other (Spe	ecify)
lon of	Attending Physician: or death. ector: Atter this certitic by the funeral director,		27. Manner of Death 1 XNatural 5 Pendii 2 Accident invest		28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f M	8c. Injun Work						occurred	
Division	tal or Attenders safter deatl	Certification:	3 Suicide 6 Could 4 Homicide determ		28e. Place build	of Injury - At I ing, etc. (Spec	home, farm, st lify)	reet, factory	y, office			28f. Loca City	tion (Str or Town	reet and , State)	Number or F	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely tilled in by	edical			r: On the b	best of my kr asis of examin ner stated.										s stated. e to the cause(s)
,	To the within 2 To the complet	Σ	29b. Signature and title of certific	er /	101	5	,	290	c. License	e number	7		29	d. Date	signed (Mon	th, Day, Year)
1	15		7h	uly	///	NA			55	80-	,	a 1		4/	1100	
	SE		30. Name and address of person Limber by MTA 31. Date filed (Month Day Year	who com	mp	7600 C	umil ,	Ave.	to	Kum	a f	ark	mi	0 2	09/	<u></u>
	Sta Regist		APR 1 4 2006	Ken	32. F	Registrar's Sign	nature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiege

State 31. Date filed (Month, Day, Year) Registrar's Signature				1 - For State Registrar	State of M	aryland / Dep. Ce	rtificate of		_	g. No.	13605
Securinory Common Security Name of the strainbox part meet and number Security Common Security Name of the strainbox part of the		Physici	an			S			Month	Day Yeer	
Special place of the property of the propert				4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	1		
To Summer State Sum											
Top State Top Concept				579-64-6659	Y				(Month, Day,		
The part of the		yland				10c. City, Town or Lo	ocation				10d. Inside City Limits
The print of the print Middle Later La		•-f •	ctor	Maryland Prince G	eorge	Forest	ville				1 Yes 2 □ No
The part of the		h with the	ai Dire		ive #303			20747	10	-	-
The part of the	900	ours after deatl	t by Funera	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	Ever in U.S. 13.			pecify Yes or No- o Rican, etc.)	Black, Whit	te, etc.
The part of the	5-0	72 h	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup	ation during most of wor	king 1	6b. Kind of Business	/Industry
A Donation S Other (Speech) Resurrection Cemetery 4/15/2006 Clinton, MD.	2121	i within liene. r then	ompi		College (1-4or	5+)				Priva	ite
A Donation S Other (Speech) Resurrection Cemetery 4/15/2006 Clinton, MD.		tal Hyg d othe	BeC								
A Donation S Other (Speech) Resurrection Cemetery 4/15/2006 Clinton, MD.	<u></u> <u> √</u>	Men	은	9							
A Donation S Other (Speech) Resurrection Cemetery 4/15/2006 Clinton, MD.	Mai	od 2 st lth and 27 Is n treun									
Physician (Model) Recurred to mode of consequence of the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Information or machine in mode of consequence of the seath of th	lore,	iges 1 ar nt of Hea H Item or other	-	1 Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	(e)	Date 2	Oc. Location - City or	
Physician (Model) Recurred to mode of consequence of the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Information or machine in mode of consequence of the seath of th	ij	it. Pa						ery 4/15/	2006 Funo		D.
23. Part. Enter heddiness, or confinedations that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Individual Cause (Final Individual Examiner) Approximate Individual Cause (Final Individual Examiner) Beautiful and the cause (Final Individual	Ва	Depermination of the police and land		wa Strict	Tikell	//	2. Name and Addres		5538 Marl	boro Pike	20747
Physician / Medical Examinor The part of				23a. Part1. Enter the a sease, or comshock, or heart failure. List only	tications that caus	the death. Do not en	er the mode of dyin				Approximate Interval Between
Due to (or as a consequence of): Due to (or as a consequence of):				disease or condition	a Stro	ke - F	ecurr-	ent			Onset and Death
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Due to (or as a consequence of): Due to (or as a consequence of):		3 6 7	- G	Sequentially list conditions, if any, leading to immediate	b. Ona to (or se	a consequence of):			_		
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FFEMALE	876	cate b physic the b	dica		. d.						
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25. Was case referred to medical sexamine?? 26. Place of Death (Check only one) 27. Maryner of Death 1		uires that t signed by Id be detad	d by Ph	- 1	ontributing to death b	out not resulting in the u	nderlying cause give	en in Part I.			7.7
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Month, Day, Year) 2. Registrar's Signature]	Hospital		(Check only 2 Medical Exam	niner: On the basis o	if examination and/or in	h consider the like vestigation, in my of	na, date and place, pinion, death occur	and due to the car rred at the time, dat	use(s) and manner as te and place, and due	stated. e to the cause(s)
30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Month, Day, Year) 2. Registrar's Signature		To the	ž	29b. Signature and title of certifier					1		•
Bahram PishDap MD 1328 Southern Ave SE, #310 Wash, DC 20032 State 31. Date filed (Month, Day, Year) B. Registrar's Signature)	(3)) rannin	M()		1 2	51520		4-06-06	2
State 31. Date filed (Month, Day, Year)	,	EL		12.1.	111			no cu A	the SI	#310 11/2	ch DC 20032
Registrar APR 1 3 2006				31. Date filed (Month, Day, Year) APR 1 3 2008	2. Registr		N. a				

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			1 - For State Registrar	State of Ma	aryland		rtment of				giene Reg. No.	000		3606	
	Physici	an	Decedent's Name (First, Middle, Last) NANCY	PRUI	TT	НОІ	RNER			2. Date of De	Day		r	3. Time of Death	Ī
	/Medio Examin		4a. Facility Name (If not institution, give st		10.	·	4b. City, Town	or Location	n of Death	HPRI		County of De	ath .	1-1-1-	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. la	ast birthday)	If Under 1 Yea		er 24 Hrs.	8. Date of Bir	th Vass)	WICOM 9. B	irthplac	e (State or Foreign	
	Director		231-42-8346	M 200 F	72	Yrs.	Months Day	s Aours	Min.	04/10/	1934		VIRC	GINIA	_
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation						10d.	Inside City Limits	_
	r 28e-f ehow	Director	VIRGINIA ACCOMAC	K	НА	LLWOOD								1 X Yes 2 □ No	
	with the		10e. Street and Number 27335 MAIN ST.				10f. Zip Code 233				10g. Citi:	izen of What (?	
2.4	deeth	Funeral		2. Was Decedent Armed Forces?	Ever in U.S	S. 13. V	Vas Decedent of Yes, specify Cu		Origin? (Spe	city Yes or No	D-	14. Race - An Black, Wh	nerican		
Homes 215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or items 23a or 28e-f ehow than "natural", or items 13a or 28e-f ehow	by Fu	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 Yes 2 XIII			☐ Yes 2 N			nicari, etc.)			WHIT		
2-0 -5	72 hours natural',		15. Decedent's Educ (Specify onfy highest grade			16a. Deced	ent's Usual Occ	upation e during me	ost of working	מי	16b. Ki	ind of Busines	s/Indus	stry	
. (4	12 should be filed within h and Mental Hygiene. 7 is marked other than ° treumatic event, the Men	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5	5+)		kind of work don DO NOT use reti HOMEMAK					DOMES	TIC		
VANCES	e filed al Hygi l other vent, L	Be Co	17. Father's Name (First, Middle, Last)						her's Name	(First, Middle		Sumame)			_
Y Nai	nould b	To	SIDNEY PRUIT			405 14-17-			ONA			- T Ct-1-	7:- 0:		
			19a. Informant's Name/Relationship (Type KEITH HORNER/SON	e, Print)			g Address (Stre CUTLER				-			ode)	
Baltimore,	ges 1 and 2 t of Health if Item 27 i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Pl	ace of Dispos emetery, crem	sition (Name of natory or other p	lace)		ate		cation - City o			
E E	pernit. Pages 1 Dep. riment of H Important: if its any injury or ot		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License.		JOHN		OR CEMETI			24/06	TEMPI	ERANCE'	VILL	E, VA	=
Ba	pemit. Dep. rtr. Imp. rts. any inji		John J. hall	amo. Lp.	A .	WIL	LIAMS FUN	JERAL H	OME, 25			ROAD, P.	ARKSI	LEY, VA 234	2
الير			23a. Part //Enter the disease, or complic shoot, or heart failure. List only one								rrest,		Int	pproximate iterval Between nset and Death	
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	Examiner		Sequentially list conclions b.	ATA	in	FI	BALL	- 4-	سر ی				3	WEEVS	i
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):									
ó	cate be executed by sician and the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as	a consequ	ence of):									
8760,	icate be physici s the bu	dlcal	d.				_								
9 xo	eath certific attending p	ın/Me	230. Was decadent pregnant	c. If yes, outcome	of pregnar	ncy death 3	Ectopic pregnar	nov.			2	23d. Date of d			
Division of Vital Records, P.O. Box	Hospitel or Attending Physician: The law requires that the death certifit 14 hours after death. Phours after death. Funerel Director: After this certificete hes been signed by the attending pely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at 9☐Unknown			Other (specify)					Month	Da	ay Year	
ď.	res that the igned by be detact	by Ph	Part II. Dther significent conditions cont	ributing to death b	ut not resu	Iting in the un	derlying cause	given in Par	t I.	23e. Did	tobacco u	ise contribute	to the c	cause of death?	
ords	v require been sig should b		li .							-	Yes 2[]No 3∏I	Probabl	ly 4 ⊟triknown	
Rec	The law sete hes b page 2 st	Completed									psy ormed?	prior to death?	o compl ?	findings available letion of cause of	
ital	ician: Th certificete rector, pag	Be Co	25. Was case referred to medical examiner?					26. Pla	ce of Death	1 ☐ Yes (Check only	2 □ 1 10 one)	1 1 1 46	es 2[No	
of V	Physic this ce	은	1 Yes 2 No	Spital: 1 Inpatie		28b. Time of	3LI DOA			ne 5 Resi		6 □Other (Sp	oecify)		_
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ivis	or Attendi fler death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Inj building, et	ury - At hor	me, farm, stre	eet, factory, offic	е	2	28f. Location (City or To		d Number or I	Rural R	loute Number,	_
۵	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Phys	cian: To the best	of my knov	wledge, death	occurred at the	time, date	and place, a	and due to the	cause(s)	and manner	as state	ed.	-
	To the Ho within 24 To the Fu completely	Medical	(Check only 2 Medical Exemin	er: On the basis of and manner sta	f examinati ated.	ion and/or inv				ed at the time,					
	Vais To Co	-	29b. Signature and title of certifier Rout B. a.	Qa	M - E			nse numbe ∟916			1	te signed (Moi	un, Da)	y, rear)	
			30. Name and address of person who cor	npleted cause of c	death (Item	23a) (Type, I	Print)								_
	ev.	10	31. Date filed (Month, Day, Year) APR 24 2	/ M_G . 32. Requal	i34 ar's Signat	6 5,	DIVISIO	ow si	-, 5	ALISI	VA7	MO	2-18	807	
	Sta Registi		APR 24 2	006	due	K.	Charles				,				

Michelle 06-02406	ਹੈ, ਰਿਕਾ ਤੇਵ੍ਯ Please Type or Print in Black Indelible Ink	
UNK, UNK	State of Maryland / Department of Health and Mental Hygical Certificate of Death	Reg. No. 2006 1360
Physician/	Registrar 1. Decedent's Name (First, Middle,Last) 2. D	ate of Death 3. Time of Death Inorth Day Year
Medical Examiner	DENISE Michelle HORSE9 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	pril 8, 2006 4c. County of Death
	Peninsula Regional Hospital Salisbury	Wicomico Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreig
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 4 O Yrs. If Under 1 Year If Under 24Hrs. 8. Hours Min. Usual Residence of Decedent	12-12-1965 Country) MD
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Reath and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 33a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10a State 10b. County Wico Mico 10c. City, Town or Location Salisbury 10e. Street and Number 10f. Zip Code	10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country?
the Marylanc a or 28a-f sh tiffed at onc	239 DOUE ST. 21801	U.S.A
D 21215-0036 should be filed within 72 hours after death with the Maryland and Merial Hygiene. 7 is marked other than "matural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Light Specify Cuban, Mexican, Puerto Rica (Specify Cuban,	
fter dea I", or it ser mus y Fur	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Specify: Black
hours after natural" Examine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work during	\sim 1 .
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) College (1-4 or 5+)	KEStaurants
21215-0036 build be filed within 7 Mental Hygene. marked other than it event, the Medica To Be Comple	1 - 1 - 1	MAE. JONES
212 ould be d Ments s mark tic even	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code)
e, MD and 2 sho fealth and item 27 is traumati	Annie Mae Jackson Mother 16743 Charles Cannon 20a. Method of Disposition (Name of cemetery, Da	
more Pages 1: Pent of H ant: If it	1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: WATERS Chapel Carneling 64-1	5-2006 Kingston, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other ir	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Uard	Tineval Home
Physician	30639 Hampdan Alea. 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res	Distance ND 21855
/Medical Examiner	failure. List only one cause on each lithe. Immediate Cause (Final disease a. Multiple Stab Wounds	Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
it xaminer	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
2 % 111	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
760, ficate be execute g physician and the burial - tran n/Medical E	UNPENDED AMENDED	
). Box 68760, the death certificate be executive the attending physician any cicked for use as the burial - trapport of the physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
5x 68 ath certi attendin or use a sicial	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be execute 74 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tell filled in by the funeral director, page 2 should be detached for use as the burial - tran all Certification: To Be Completed by Physician/Medical E	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the state death. *I Director: After this certificate has been signed by led in by the funeral director; page 2 should be detact errification: To Be Completed by F		1 Yes 2 ✓ No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available
Records, I : The law requires fricate has been sig		autopsy prior to completion of cause of performed? death?
Vital Rec vysician: The la this certificate h I director, page.	25. Was case referred to medical 26.Place of Death (Check only	1 Yes 2 No 1 Yes 2 No one)
f Vital Physician: r this certi ral director	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing H	
on of nating P the refuner is funer is	1 Natural 5 Pending FOUND: 1 Yes 2 V No Su	d. Describe how injury occurred bject stabbed
Division o spital or Attending outs after feath neral Director: After filled in by the fune Certification:	2 Accident Investigation Apr 8, 2006 06:15 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f	Location (Street and Number or Rural Route Number, City or Town, State)
Division of N To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral ledical Certification: T	4 Homicide determined (Specify) Found in backyard 306 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due	5 Naylor Stréet, Salisbury, MD
To the Ho within 24 To the Fu completely	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e time, date and place, and due to the cause(s)
H % H %	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d Dateysigned (Month, Day, Year)
	30-Name and address of person who completed educe of death (Item 23a)	, if the
	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra	31. Date filed (Month, Day, Year) APR 1 8 2006 32. Redistrar's Signature	
DHMH 17 Rev 1/2001	ORIGINAL	

DHMH 17 Rev 1/2001 OCME 10/2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrer	State of Maryland			of Health and of Death		glene O	06	13608	
	Physici	an	Decedent's Name (First, Middle, Last)	II-1				2. Date of Dea		20 0 6ar	3. Time of Death 12:50 PM	
	/Medic	al								12.50 IM		
	Funeral Director	EI	Long View Nursing Home Manchester Carroll									
			5. Social Security Number 215-10-7258 6. Sex 1-1 M 2 1 M 2 1 M 2 1 M 2 1 M 2 1 M 2 M Nonths 1 M Non								lace (State or Foreign try) aryland	
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 ie marked other then "netural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be rotified at once.	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Upperco 1 □ Yes 2 № No									
		al Direc	10e. Street and Number 15212 Old Hanover Road 10f. Zip Code 21155 10g. Citizen of What Country? United States									
920		Completed by Funeral Director		. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2000 No If Yes, Give Year or Dates:		Vas Deceder Yes, specifi	nt of Hispanic Origin? Cuban, Mexican, Pu XNo Specify:	(Specify Yes or No- erto Rican, etc.)	14. R B	ace - Americ lack, White, city: Wh:		
5-0		eted	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Deced (Give	ent's Usual (Occupation done during most of v retired)	vorking	16b. Kind of	Business/Inc	dustry	
Maryland 21215-0036		To Be Compi	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		oo not use emaker			Owr	n Home		
Bu			17. Father's Name (First, Middle, Last)					lame (First, Middle,		ame)		
Z			Harry Gree	T-	19b. Mailin	a Address (S	Cari			m. State. Zin	Code)	
			Kathy Sauter (Daughter) 15212 Old Hanover Road Upperco, MD 21155									
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State Lak	e Vie		Park Api			kesvi	11e, MD	
Balt	permit. Pe Departmer important: any injury once.		21. Signatule of Funeral Service Licensee	aur	B 1	Name and Urrier 212 W.	Address of Facility Oueen Fui Old Libei	neral Home rtv Road	e & Cre Winfie	emator	y, PA D 21784	
	Physician /Medical Examiner	ner	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of) Due to (or as a consequence of)									
x 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	d									
.O. Box			23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ect 4 Pregnant at time of death 5 Ott						23d. Date of delivery Month Day Year			
rds, P.									contribute to the cause of death?			
Il Records,								24a. Was a autop perfor		were autor prior to con death? 1 \(\subseteq \text{Yes}	osy findings available inpletion of cause of	
Vita			25. Was case referred to medical examiner? 26. Place of Death (Check only one)									
Division of Vital			27. Manner of Death VNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?					me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Divis			3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	ne Hospi 24 hou ne Funer letely fill		29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the To the comp		29b. Signature and title of certifier	2 2 ~			icense number		29d. Date sign	ed (Month, L	Day, Year)	
WIL Whole Z. Ryberg, D. O. HOO6 1206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. RYB									4/11/06			
	6		4/75 A 9/0	rover Pip	ke	Man	cheste	2745	٠	1102	*	
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 1 7 20	32. Registrar's Signatur	re M	land.						

			For State Registrar	State of Maryland	/ Depa		Health a		ntal Hygi	3	13609
			Decedent's Name (First, Middle, La	st)				2.	Date of Death)	3. Time of Death
	Physici /Medic		ALICE VERONICA	HOLLAND				A	Month pril 7	Day Yea 2006	10:35 p M
	Examin		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of			4c. County of De	
			6709 Hamilton S			Riverd					George's
	Funeral		5. Social Security Number 6. S	□M 2KTF	t birthday) Yrs.	If Under 1 Year Months Days			Date of Birth (Month, Dey,		inthplace (State or Foreign Country)
	Director		023-09-7078 Usual Residence of Decedent	94	113.			M	ay 27,	1911 Ma	issachusetts
	yland yland		10a. State 10b. County	10c. City, 1	Town or Lo	cation					10d. Inside City Limits
	Mar e-f st	tor	Maryland Prince	George's Riv	erda1	.e					1 X Yes 2 □ No
	ith the	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of What	Country?
	ath w		6709 Hamilton S			2073				J.S.A.	
	er de Items	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 📉 No	13.	Was Decedent of I f Yes, specify Cub	Hispanic Orig an, Mexican,	jin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	hours after death with the Marylan urel', or Items 23e or 28e-f show al Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify: W	hite
21215-0036	within 72 hours after death with the Maryland one. then "neturel", or Items 23e or 28e-f show the Madical Examiner must be notified at	ted	15. Decedent's E	ducation	16a. Dece	lent's Usual Occu	pation		1	6b. Kind of Busines	
215	thio 72 ho e. en "netur Wedical	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done OO NOT use retire	auring most ad)	or working			
7	74 Table 148	Co	12		Sale	S				Retail	
P P	be de la	Be	17. Father's Name (First, Middle, Last,				18. Mother	r's Name (F	irst, Middle, M	aiden Sumame)	
2		10	Thomas Gugarty 19a. Informant's Name/Relationship (Tuna Print)	10b Mailie	a Address (Street		Howe	auta Akumbar	City or Town, State	Zin Codo l
Maryland	7 1s		Robert C. Holla								
	s 1 and 3 of Health Item 27 other tr		20a. Method of Disposition		e of Dispo	nallittto sition (Name of natory or other pla	n stre	Date		De Marvi Oc. Location - City	and 20737 or Town, State
E C	0 0 = =		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif					4/11/	2006	Silver Sp	ring, Maryland
Baltimore,	= モゼラー		21. Signature of Funeral Service Logi							neral Hom	
m	Deparmi Deparmi Impo any ir		Auto	May	4	739 Balt	imore .	Ave.,	Hyatts	sville, M	aryland 20781
			23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that sed the death.	Do not ent	ar the mode of dyi	ng, such as c	cardiac or re	spiratory arres	st,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a Colon Carcin	oma v	vith Inti	aabdon	minal	Metast	ases	Onset and Death 1½ Years
	/Medical Examiner		resulting in death)	Due to (or as a consequer					100000000000000000000000000000000000000		
		-	Sequentially list conditions,	b. Due to (or as a consequer	on offi						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes of Figure	240 (0) 40 4 00 100 4401	100 01).						
Ć.	execu n and ial-tra	Examine	that initiated events resulting in death) Last	CDue to (or as a consequen	nce of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	cai		d							
9	leath certifical attending phy I for use as th		IS SELVING								
Вох	th cer tendir r use	an/\	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance		Ectopic pregnanc	·v			23d. Date of d	
	at the dea by the at tached fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of deat 9☐ Unknown	h 5 [Other (specify)				Month	Day Year
P.0	that the		Part II. Other significant conditions of	ontributing to death but not resulting	ng in the u	derlying cause at	ven in Part I		23e Did toba	acco use contribute	to the cause of deeth?
Records,	sign sign d be	ed by	Senile Dementi		19 11 1110 01						Probably 4 □Unknown
BCC	law requas been 2 shoul	Completed	Diabetes Melli	tus II					24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
<u> </u>	The ate h page	Son							perform		7
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	II Set				of Death (C	heck only one)	
of	Physi this c	2	1 ☐ Yes 2 🔯 No 27. Manner of Death	Hospital: 1 Inpatient 2 EP		1 3 DOA				nce 6 Other (Sp winjury occurred	pecify)
		tion	1 XNatural 5 ☐ Pending	(Month, Day Year)	Bb. Time of Injury	Wo	rk?]Yes 2.⊟N		. Describe nov	winjury occurred	
Division	en or: he	ficat	3 Suicide 6 Could not b		e, farm, str		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Location (Stre	eet and Number or	Rural Route Number.
Div	i diffe	Certification:	4 Homicide	building, etc. (Specify)		,,			City or Town,	State)	
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai C	29a. Certifier 1	ysicien: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death and/or in	occurred at the tivestigation, in my	me, date and opinion, death	d place, and h occurred	due to the cau at the time, dat	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	00		29c. Licen			290	d. Date signed (Mo.	nth, Day, Year)
			lette In les	Meh		D	2270	fo	A	pril 11,	2006
0	(15)		30. Name and address person who	completed cause of death (Item 23	За) (Туре,	Print)			1	,	
_	()		Peter M. Schiss			y Center	Drive	e #430), Gree	nbelt, MI	20770-3542
	Sta Registr		31. Date filed (Month, Dey, Year) APR 1 1 200	Registrar's Signatur		de la					

			1 - For State of Registrar	Maryland / Dep	artment of <i>rtificate of</i>			Hygier	(UUb	13610
ľ	Physici		1. Decedent's Name (First, Middle, Last) Wayne Ralph Horn				2. Date Mont Apri		Day Year 2006	3. Time of Death 8:15 A M
	/Medio Examir		4a. Facility Name (If not institution, give street and num.	ber)	4b. City, Town,	or Location of			4c. County of Death	
	_xaiiii		241 Bard Cameron Road		Rising	g Sun			Cecil	
	Funeral Director		220-66-6642 1XIM 2□F	. Age (In yrs. last birthday) 50 Yrs.	Months Day		Min. 8. Date (Mont	of Birth th, Day, Yes DOCK 1	9. Birth	place (State or Foreign ntry) MD
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				,	10d. Inside City Limits
	Mary Pa-f sh	to	MD Cecil	Rising	Sun					1 ☐ Yes 2 💢 No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. (Citizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show rmust be notified at		241 Bard Cameron Road		2191	-			ISA	
0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23a or 28a-f show svent, the Medical Exactiver must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 If Yes, Give	No No	was Decedent of If Yes, specify Cu 1 ☐ Yes 2 X No		gin? (Specify Yes n, Puerto Rican, etc	or No- c.)	14. Race - Ameri Black, White, Specify: White	etc.
ž	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occ	upation	A = 4 = 4.1= =	16b.	Kind of Business/In	
2 2	thin 7. e. an n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4or 5+)	kind of work don DO NOT use retir	red)				
V	filed wi Hygien other th	Con	12	Pro	duction				Flooring	
and		Be c	17. Father's Name (First, Middle, Last) Herbert Horn				ets Name (First, M atrice Hu		en Sumame)	
5	s 1 and 2 should to the alth and Ment tem 27 is marked other traumatics	스	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stree				y or Town, State, Zip	Code)
Ma	and 2 salth a n 27 is		Cynthia Horn/wife	241	Bard Can	neron 1	Road, Ris	sing S	Sun, MD 2	1911
e.	of He of He fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pi	lace)	Date 04-18-200	20c.	Location - City or To	own, State
altimor	Pages ment of ant: if it		*4 Donation 5 Other (Specify)	R.T. Foar		rl Home	2, P.A.	Ri	sing Sun,	MD
Dall	permit, Pages Department of I important: if it any injury or o once.		21. Sign that of Fundal Service Licensee	\mathcal{L} 1	2. Name and Add	ress of Facilit 12en Sa	y R.T. Fo t., Risin	oard F 1g Sun	uneral Ho 1, MD 219	
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not en ch line.	ter the mode of dy	ying, such as	cardiac or respirat	ory arrest,		Approximate Interval Between
á	Priysician		Immediate Cause (Final disease or condition resulting in death)	astatic Co	mamon	a of	Gastro	scylia	540	Onset and Death
	/Medical Examiner		Due to (o	r as a consequence of):		1		1		
		ē	Sequentially list conditions, a any, reading to intrinsidate.	r as a echsoquenee of):						
	outed Id ansit	Examiner	Sequentially list conditions, a day, leading to arminodate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ď,	e exection and an			r as a consequence of):						
0/00	icate be executed physician and s the burial-transit	dical	d							
o X O	certific nding p use as	a a	IF FEMALE: 23c If yes putc	ome of pregnancy					2010	
0	that the death certifi ed by the attending p detached for use as	Physiclan/M	in the past 12 months?	th 2 ☐ Fetal death 3 [☐Ectopic pregnan☐ Other (specify)	су			23d. Date of delive Month	ery Day Year
ַכ	the d	hysi	1 Yes 2 No							
Sp.	Se O	by	Part II. Other significant conditions contributing to dea	th but not resulting in the u	ınderlying cause g	given in Part I.	. 23e.		o use contribute to to	he cause of death?
Records	> 0 0	Completed						Was an	24b. Were auto	psy findings available
	9 4 9	om					101	autopsy performed? Yes 2	death?	mpletion of cause of
NI G	ysiclan: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				of Death (Check			
5	d S	ပို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In	patient 2 ER/Outpatie	IL JUDON				6 □Other (Specif	y)
		tlon:	27. Mann eath 28a. Date of (Month) 1 Natural 5 Pending (Month) 2 Accident investigation	Injury 28b. Time of Injury	W	uryat ork? ⊒Yes 2.∐i		cribe now in	jury occurred	
DIVISION	r Atten ter deal irectors i by the	Certificati	3 Suicide 6 Could not be determined 28e. Place of	f Injury - At home, farm, st g, etc. (Specify)	reet, factory, office	Э	28f. Locat	tion (Street or Town, Sta	and Number or Rura	al Route Number,
	oital o urs af eral D	Cel		· · · · · · · · · · · · · · · · · · ·						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	29a. Certifier 1 Tertifying Physician: To the base one) 2 Medical Examiner: On the base and manner	is of examination and/or in	h occurred at the vestigation, in my	time, date and opinion, deal	d place, and due to th occurred at the	o the cause time, date a	(s) and manner as s and place, and due to	tated. o the cause(s)
	To the Comp	Ž	29b. Signature and title of certifier			nse number			Date signed (Month,	
			· III Askel	<u>.</u>	D:	3565	53	4	1/18/00	
	5		30. Name and address of person 10 completed cause		Print)	11:1	5+ 5+	1, 100	FIKton	MD 21921
	Sta	ate	31. Date filed (Month, Day, Year) 32. Re-	gistrar's Signature	I LL VV	· Laidu	1 0[1 01	~ -	~ 1F10F1	11/2 2/12/1
	Registi		APR 1 8 2006 Keeper	gistrar's Signature	,					

1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Etta Lynn Hitchcock Anri 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** o.F Union Cecil County EIKTON Cecil ltospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Director 208-50-8041 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show 1 XYes 2 No Director Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 37 Mahogany Drive 21901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status 14. Race - American Indian, filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. eny injury or other treumatic event, the Madia once. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gilbert Ranson Edwards Constance Lynn Sumner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Hitchcock, Jr./Husband 37 Mahogany Drive, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake City, 20a. Method of Disposition April 26, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bethel Cemetery 2006 Maryland 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) **Physician** Scuere 5 ders Q40Krc /Medical Due to (or as a consequence of) Examiner Respirator. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1□Live birth 2 □Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten e detached for u 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Cerebra 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 € No 1 inpatient Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury within 24 hours after death. To the Funerel Director: A completely filled in by the fu 1 Yes 2 No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a Duo Min DO055 190 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital 106 BOW St Elkton. Union Pirro MP 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2006

HI TChCock, SHC

			1 - For State Registrar	State of Maryla	•		of He	ealth a		lental Hyg	giene	6	13612
	Dhorie		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medi		ANNA LOUISE	HEARN						APRIL		2006	3:00 P ^M
	Examir		4a. Facility Name (If not institution, give	·		4b. City, T	own, or	Location of	of Death		4c. Count	y of Death	
			FRIENDSHIP HOU				LIN	17.17.	2410-1			RCEST	
	Funeral		5. Social Security Number 6. Se	7 M OFF	rs. last birthday) R6 Yrs.	If Under 1 Months	Days	If Under:	Min.	8. Date of Birth (Month, Day	, Year)	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	K (36 Yrs.				(OCT. 31	, 1919	MAI	RYLAND
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation							10d. Inside City Limits
	Mary 1 sh	to	MARYLAND WORCEST	rer	BISHO	PVILL	F.						1 ☐ Yes 2 🛣 No
	128a	rec	10e. Street and Number			10f. Zip 0					10g. Citizen of	What Cou	ntry?
	3a o	Funeral Director	11313 BACK CREEK	ROAD		2	1813				US	SA	
	deatl	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Vas Decede	nt of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Ra	ce - Ameri	
ဖွ	or the	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		ires, specii 1 □ Yes 2l		Specify:	i, rueito i	rican, etc.)		ack, White,	
8	ours ral',	d by	3 X Widowed 4 □ Divorced	Year or Dates:		165 21	21.110	эрвину.			Spec	W. W.	HITE
21215-0036	72 h natu	Completed	15. Decedent's Edu (Specify only highest grad	ication le co <i>mpleted)</i>	16a. Deced (Give	lent's Usual kind of work OO NOT use	Occupat done du	tion <i>uring most</i>	t of workir	ng	16b. Kind of I	Business/In	dustry
7	within ne.	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		DMINI:					нем	LTHCA	DF
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tiems 23a or 28a-1 show ont, I're Medical Exar in ser must be a callied at		11 17. Father's Name (First, Middle, Last)						r's Name	(First, Middle,			XICL
anc	ould be f Mental I wrkad o	Be	THOMAS	HENRY	CATHELL				DITH	_	н.	QUII	TEN
Ξ	should Ind Menion Menio	2	19a. Informant's Name/Relationship (T)		-		Street au			l Route Numbe			
Maryland	d 2 should be sh		LOUISE T. LYNCH/I		. 3), BISH	•		
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, I've Medical Exert in per first Lexivalilies at		20a. Method of Disposition		. Place of Dispo	sition (Name	of	1		ate	20c. Location		
Baltimore,	Pages nent of I ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ F 3 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren ST • STEP			'	4/21	1/06	DELMYE	DET	ALIADE
ቜ	그 는 단 등 .		21. Signature Juneral Service Licens	The same		. Name and		of Facilit		1,00	DELMAR	, DEL	LAWARE
Ba	permi Depa Impo any i		1/1/20/1/	2/set					•	ME, SELI	BYVILLE	DE.	19975
			23a. Part . Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de									Approximate Interval Between
E	Dhysisian		Immediate Cause (Final		JASCUL			IDER					Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	-	77	ne	. P D IC	1				
	Examiner			CONGLES	211	HEI	PI	P	416	UR.			
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):		1	-					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CARDIO	1440 PA	HHY	/						
o,	sician and burial-transit	Exa	resulting in death) Last	Due to (or as a cons	equence of):								
68760	Attending Physician: The law requires that the death certificate be executed or death. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ical		d									
89	ng ph	Physician/Med	IF FEMALE:										
Вох	eath certific attending pl	an/I	23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pred	nancy				1	ate of delive	•
Э.	the at	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	f death 5□	Other (spec	city)				M	onth	Day Year
P.O.	that the de ed by the detached	Phy	9 Unknown							On Dida			be seen of death?
	res tha signed I be det	þ	Part II. Other significant conditions co	ntributing to death but not r	esulting in the ur	nderlying cat	ise giver	ın Part I.		J.		itribute to ti 3 □ Prot	he cause of death?
0.0	w require been si should b	ted	1000 10	b by the T	1 1911	777					es 2 No	3 F100	pably 4 QUnknown
Division of Vital Records,	elaw hasb je2st	Completed	_ voti !) KETSI	CANC	EK.				24a. Was a autops	sy	prior to co	psy findings available mpletion of cause of
<u> </u>	an: The tificate ha tor, page	S	HYPED I	ITURUD ISP						perfor	med? 2⊠No	death?	2 🗆 No
/ita	ician: T certifical rector, p	Be	25. Was case referred to medical examiner?	In-mitals					of Death	(Check only or	ne)	стеть	D I TUTNO
_	hysi this c	မ	I res 2 Divo		ER/Outpatien			4 LI Nui		ne 5 Resid		SISTE ner (Specif	LIVING
Ē	ding Physicia h. After this certi funeral directo	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		. Injury Work			28d. Describe h	ow injury occu	rred	
S	Nttendideath.	cat	2 Accident investigation 3 Suicide 6 Could not be	00 80 (1-1 44	hama farm at	M		es 2⊡N		196 pasting /C	tunn to mark \$ trum	han	of Courts through a
Ξ	or Al	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)	et, factory,	опісе		4	City or Town		Dei Or Hura	al Route Number,
_	To the Hospital or Attenc within 24 hours after deatt To the Funeral Diractor: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of my k	nowledge death	occurred of	the time	date acc	d place o	and due to the e	alice/c) and	anner ac a	tated
	24 hi 24 hi Fun stely	Medical	(Check only 2 Medical Exami	ner: On the basis of exami and manner stated.	nation and/or inv	restigation, i	n my opi	nion, deat	th occurre	ed at the time, d	late and place,	and due to	the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier	0 1 -		29c.	License	number		2	9d. Date signe	ed (Month,	Day, Year)
	FSFÖ		1 Mha	4. MD.			1))	2874	18		4-1	8-0	6
	Br		30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type	Print)	V				1 [-	/
	1D		WAHE CAN	17/1/02. K	1-1) 1 7	14 F	PH	NKU	N	AVE .	BERI	IN.	MD 2181
	Sta	ite	31. Date filed (Month, Cay, Year)	32. Pogistrar's Sig	nature /		1		IV I	1		1	1 1
	Registr		APR 1 8 2	JUG Malera	K A	mall 1							,

			For Stete Registrar	State of Maryland		rtment of t		nd Men		ene () ()	16	13613
			Decedent's Name (First, Middle, Last)			-			ate of Death			3. Time of Death
н	Physici /Medic		VIRGIL JONES						Month ril 12	Day 2006	Year	3:00 p M
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of	Death		4c. County	of Death	
			4104 53rd Avenue	-		Bladen	_					orge's
Ŷ.	Funeral Director		5. Social Security Number 6. Sex 1 ☑ 6. Sex	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. (/	ate of Birth Month, Day, 1 n. 26,	^{Year)} 1937	9. Birthr Cour Virg	
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Loc	cation					Τ.	10d. Inside City Limits
	Aaryla Faho ed al	5										1 X Yes 2 No
	the A	rect	Maryland Prince G	eorge's Blad	ensbu:	rg 10f. Zip Code			10	g. Citizen of V	Vhat Cour	
	3e or		4104 53rd Avenue	Apt #1		20710				J.S.A.		,
	death	Funeral Director		2. Was Decedent Ever in U.S.	. 13. V	Vas Decedent of I	lispanic Origi	in? (Specify	res or No-	14. Race		can Indian,
ဖွ	after or Ite	/ Fui	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 XYes 2 No 196(If Yes, Give)-	Yes, specify Cub ☐ Yes 2 No		Риепо нісаг	1, etc.)		k, White,	
000	hours urel',	d by	3 Widowed 4 Divorced	Year or Dates: 1962						Specify	WIII	
<u>7</u>	"net	Completed	15. Decedent's Educ (Specify only highest grade		(Give I	ent's Usual Occuj kind of work done OO NOT use retire	during most of	of working	16	6b. Kind of Bu	siness/In	dustry
7	withi iene. then	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Drive		۵)			UPS		
ਰੂ	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)		DIIVE		18. Mother	's Name (Firs		aiden Sumam	Θ)	
Maryland 21215-0036	uld by Wenta rrked	To E	Virgil Jones				Annie	e Harr	iet Yo	st		
an	2 sho and I is me eume	·	19a. Informant's Name/Relationship (Type	ne, Print)	19b. Mailin	g Address (Street	and Number	or Rural Rou	ite Number, (City or Town,	State, Zip	Code)
≥ ∴	and lealth m 27 her tr		Nancy Jones - Wife		4104	53rd Av	enue,	Apt #	1, B1a	densbu	rg,	MD 20710
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23e or 28e-1 show eny injury or other treumetic event, the Medical Examinat Frust be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	netery, crem	sition (Name of natory or other pla				0c. Location -	,	
量	it. Pa rtmer rtent njury		'4 □Doyation 5 □ Other (Specify) 21. Sign sture 1 Fun ral Service Li		land_V	eterans Co	emetery	4/17/2	2006	Chelte:	nham	Maryland
Ba	perm Depa Impo eny i		Ac de 1	1/65		Name and Address 39 Balt:						
			23a. Part1 Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.							rio ,	Approximate
	Physician [*]		Immediate Cause (Final	/								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Cancer of Lur Due to (or as a conseque								
L	Examiner		Sequentially list conditions, b									
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	nce of):							
	xecuti and II-tran	хап	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):							
8760,	ficate be executed physician and s the burial-transit	dlcal E										
687	ificate g phy: as the	a										
Box	The law requires that the death certific Ite has been signed by the attending p bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant	Bc. If yes, outcome of pregnand 1□Live birth 2□Fetal d		Ectopic pregnanc	,			23d. Date		,
	a deat he ath ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of dea 9☐ Unknown		Other (specify) _	,			Mor	nth	Day Year
<u>Р</u>	that the de led by the a detached t	Phy	9 Unknown						. Dida.			
	ires tha signed I be del	by	Part II. Other significent conditions con	tributing to death but not result	ing in the un	derlying cause giv	en in Paπ I.	1				ne cause of death?
Ö	w requir been si should	etec										
Records,	sicien: The law s certificate has k lirector, page 2 s	Completed						2	4a. Was an autopsy performe	p	Vere auto rior to coi eath?	psy findings available mpletion of cause of
Vital		e Co	25. Was case referred to medical				00.01		☐ Yes 2	No 1	Yes	2□ No
	ysicien: is certific director.	0 8	examiner?	ospital:	R/Qutpatient	3 DOA Ott	on	of Death (Che		ce 6 □Othe	r (Snecifi	(r)
O	Attending Physicien: r death. ector: After this certifica	n: T	27. Manner of Death		8b. Time of Injury	28c. Inju	y at			injury occurre		,
Ö	tendin death. tor: Aft the fur	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Moran, Day 16a)	пциту		Yes 2 □ No	0				
Division of	l or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. L	ocation (Stre	et and Numbe State)	er or Rura	l Route Number,
	lospitel c		¥									
	24 24 ale	Medical	29a. Certifier 1 ⚠ Certifying Phys (Check only one)	ician: To the best of my knowler: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tile estigation, in my o	me, date and pinion, death	place, and d occurred at	ue to the cau the time, date	ise(s) and mai e and place, a	nner as st ind due to	ated. the cause(s)
	To the Ywithin 2 To the Complet	Me	29b. Signature and title of certifier			29c. Licens	e number		290	d. Date signed	(Month,	Day, Year)
)	8		· acquison	ne MO		D16	619		l A	April 1	4, 2	2006
`	13/00		30. Name and address of person who con	npleted cause of death (Item 2	3a) (Type, F					-		
P	2		Corazon Vergara-So			klin Squ	are Dr	ive, B	altimo	ore, Ma	ryla	nd 21236
	Sta Registr		APR 1 4 2006	32. Registrar's Signatu								
			*** ** * * COOO ***									

			1 - For State Registrar	State of Mary	-	artment of H			iene () ()	6 13	6 l	4
	Physici	an	Decedent's Name (First, Middle, Las	t)			·	2. Date of Deat Month	Day	Year	e of De	
ig.	/Medic Examin	al	Jeane Julian 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea		9, 200 4c. County		:6	A M
*	Examin	eı	4880 Elmer Derr			Jeffers				derick		
\$. (g)()	Funeral Director		5. Social Security Number (unk) 6. Security Number (unk)	ox 7. Age (lr ☐ M 2 🔏 F	yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		Year) 1946	9. Birthplace (St. Country)		oreign unk)
	and 1		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. insid	e City I	Limits
	Maryi -1 sho fied a	tor	Virginia Albemarl	e C	harlottsv	7i11e				1 🗆	Yes 2	X □No
	th the or 28a	Jirec	10e. Street and Number	•	1101 10 0 00	10f. Zip Code	 	1	0g. Citizen ol \	What Country?		
	eth w	rail	1234 Pebblebrooke			22902			JSA	A (((((((
36	be filed within 72 hours after deeth with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Martical Experience interior by notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 _Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, sp <i>eci</i> fy Cuba 1 ☐ Yes 2[X] No	spanic Origin? (n, Mexican, Pue Specity:	(Specify Yes or No- erto Rican, etc.)	Blac	e - American India ck, White, etc. White	1,	
5	72 hou	ted	15. Decedent's Ed (Specify only highest grad	ucation		dent's Usual Occupa		orkina.		usiness/Industry		
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)					
7 2	filed with Hygiene. other thar ent, the N		12 17. Father's Name (First, Middle, Last)		Manag	ger	18. Mother's N	ame (First, Middle, A		tion Tecl	inol	Logy
Maryland 21215-0036	g g g	To Be				(unk)					(ur	nk)
	d2 strauth arr		19a. Informant's Name/Relationship <i>(T</i> Leslie Takahashi M			-		Rural Route Number, ${\sf ottsville}$,				
e,	s 1 and 3 f Health item 27 other tra		20a. Method of Disposition	1	20b. Place of Dispo	sition (Name of matory or other place	e) At	oril 14,	20c. Location -	City or Town, Star	е	
Ē	Pages ment of ant: If it ury or o		1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	Chesapeal	ce Cremato	ory 2	2006 E		lle, Mary		nd
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 sny injury or other 2002.		21. Signature of Funeral Service Licent	11-14	01251 Be	Name and Address oing Home everly L.	s of Facility Cremati Heckrot	ion Servic	e P.O Clarks	. Box 784 ville, M) 21	1029
			23a. Part 1. Enter the disease, or composhock, or heart lailure. List only of	olications that caused the one cause on each line.			,			Approx Interva Onset	Between	en ath
): I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hsphyxi		to in	halatio	on ofen	roust	unes		
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Se.	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ensequence of):							
	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):							
8/60	e be e /sicien e buriz	dicai E		d								
9	rtificat ng phy as th	Medi	IF FEMALE:									
Pox	death certific e attending p od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy				te of delivery onth Day	Yea	ar
	0 0	ysic	1 □ Yes 2 X No 9 □ Unknown	4□Pregnant at time 9□Unknown	e of death 5	Other (specify)				·		
S,	requires that the	by Pr	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	20	ribute to the cause		
ecord	w requir been si should i		400-1					1 🗆 Ye	/-		Unk	
Hec	The law ate has b page 2 s	Completed						24a. Was a autops perforn 1 Yes 2	ned?	Were autopsy findi prior to completion death? 1 ☐ Yes 2 No	ngs ava	ailable se ol
Vital	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	2∏E0/0	ot 3 DOA Othe	20	eath (Check only on	10.00	0 11/1	CAZ	15V2 5
	g Phys er this eral dir	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	IL OLI DON	at	Home 5 ☐ Reside	w inju v occur	red.	200	NC
Sior	Attending Fir death. ector: After by the funer.	Certification:	1 Natural 5 Pending 2 Accident investigation	April 9,20	06 UNKnow	UM 10		placed		ir windo		
Division		rtiffe	3 Suicide 6 Could not be 4 Homicide determined	28e. Plac I Injury building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (St. City or Town	Contalid	er or Rural Route	/1	" Re
_	Hospital 4 hours Funerel tely filled	edical Ce	(Check only 2 Medical Exam	ysician: To the best of miner: On the basis of ex	amination and/or in							nd
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated	•	29c. License	number	25	9d. Date signe	d (Month, Day, Ye	ar)	
)	- ≯ ⊢ ŏ		· 180.	to. 0.	MNDA	I DE	3719					6
	22	- 5	30. Name and address of person who o	completed cause of death	(Item 23a) (Type,	Print)		7 redevirk,				
チ)		19813	Alan Sphren 31. Date filed (Month, Day, Year)	MD 15 32. Relistrar's	Wast	1555V	cet Fr	edevirk,	MD	21701	,	
	Sta Registr	1		nns 32. Hanstrars	Signature	land.		,				

ARTHUR JONES 220-10-6544

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day thur JUnes DRIL 2000 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL PONI NSULA AICIMICO anter 5AUB541 If Under 1 Year If Under 24 Ars. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months 1XM 2□ F 9 220-10-65 MD Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MD Somerset 1 Yes 2 No Directo Tance 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23800 21816 238 all Webster Rd U.S Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, or iteme 11. Marital Status Black, White, etc. 1 Dyes 2 No If Yes, Give Year or Dates: ARM 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 2 BIAC 3 Widowed 4 □ Divorced natural Completed A6a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7 th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Mental 8 Doug 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23800 : If item 27 E -4V/Webster 1405/4/1-Jaughter 20a. Method of Disposition MD 21816 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Surial 2 Cremation 3 Removal from State permit. Page Department o important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Charles U.M. ch Cerrita hance 21. Sign ture of Funeral Service*Licensee 22. Name and Address of Facility ennie bellast-Salis 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Premonia **Physician** ZY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and shed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? δ Records. 2 □ No Completed 1 ZYes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2 - NO within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☑ No Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Division 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kode 218 NES 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State APR 1 8 2006 Registrar

			1 = For State Registrar	State of M	arylan	d / Dep	artmer	nt of H					06	13616
	\$ 86 ₄	*	1. Decedent's Name (First, Middle, Las	t)					-		2. Date of Deat Month		V	3. Time of Death
7	Physici /Medio		Tommy Kirkla	nd							April	Day 8	Year 2006	1627 P M
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City	, Town, or	Location o	f Death		4c. Cou	inty of Death	
Repair H		50).	Gladys Spellma						Cheve			Pr	ince G	eorge's
10	- Funeral		Social Security Number 6. Se	7. Ag ∑M 2□F	ie (In yrs. la	ast birthday)	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
44	Director		248-66-0927 Usual Residence of Decedent	•	6	7Yrs.					Aug. 2,	1938	Sout	h Carolina
	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation							IOd. Inside City Limits
	Mary f sh	Ď	DC						Was	hing	gton			1 XYes 2 No
	728a	Jec.	10e. Street and Number				10f. Zi	o Code			-	0g. Citizen	of What Cour	ntry?
	3a o	2	4624 - 6th St.	SE.					20	032		TI-	nitad	States
	deet ma 2	Funeral Director	11. Marital Status	12. Was Decedent		S. 13.	Was Dece	dent of Hi			ecify Yes or No- Rican, etc.)	14. F	Race - Americ	can Indian,
9	or its	F	1 ☐ Never Married 2 ☐XMarried	Armed Forces? 1 Yes 271 If Yes, Give						, Puerto	Hican, etc.)		Black, White,	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:			1 🗆 Yes	X-1 №	Specify:			Spe	city: B1	ack
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural; or itema 23a or 28a-f show ha Mudical Examitter must be notified at	Completed	15. Decedent's Ed (Specify only highest grad			16a. Dece (Give	kind of wo	ork done a	luring most	of worki	ing	16b. Kind o	Business/In	dustry
7	withir	Ę	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT L	ise retired,)					
	Hygie ther int,	ပိ	6th t7. Father's Name (First, Middle, Last)				I	Rodma		r's Name	(First, Middle, M	Maiden Sur	Priva	te
an	d be sental	o Be	Joe Richbo	NT.7					70. 141011101	3 1101110			ianto,	
Maryland	Shoul od Me mari	To.	19a. Informant's Name/Relationship (7			19b. Mailir	na Addres	s (Street a	and Number	r or Rura	Ethel Al Route Number,	_	wn State Zin	Codel
	nd 2 ulth ar 27 le r trau		Amelia Kirklar	nd/Wife							sh., DC	•	, 5.0.0, 2.10	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Mudical Examined must be notified at ance.		20a. Method of Disposition		20b. Pl	ace of Dispo emetery, crer	sition (Na	me of					on - City or To	own, State
Ë	Page ent o nt: If		1 Burial 2 Cremation 3 :			Linc				4/15	5/2006	Date	. + J	MD
Baltimore,	mit. partir sorts / inju		21. Signature of Furieral Service Licens						s of Facility		ewart F		ntwood	, IIID
m	Depa Impo any ir		John T.	Sleion	11		400)1 Be	nning		, NE W			019
(%)	- 5		23a. Part1. Emer the disease, or comp shock, or heart failure. List only of	lications that caused	the death	. Do not ent								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Vasc	นไลร	Dise	ase					Onset and Death
*	/Medical		resulting in death)	Due to (or as				2200	<u> </u>					
	Examiner		Sequentially list conditions	b. Diabe	tes M	lellit	us							
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):								
	and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	c										
760,	cate be executed physician and the burial-transit		4	Due to (or as	a consequ	ence or):							ľ	
687	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	•	d										
	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnan	ncv						004	Date at dalling	
ĕ	atter I for u	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic p Other (se						Date ol delive Month	Day Year
P.O. Box	the d y the	isku	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			201101 (0)							
	w requires that the de been signed by the should be detached	by Pi	Part II. Other significant conditions co	ntributing to death b	ut not resul	Iting in the u	nderlying o	ause give	n in Part I.		23e. Did tob	acco use co	ontribute to th	ne cause of death?
ğ	quire nn sig uld b	p p	Respirat	ory Failu	re						1 ☐ Ye	s 2 No	3 🏻 Prob	ably 4 XUnknown
၀	s bee	Completed	Cerebra1	Infarcti	on wi	th En	cenha	1ona	thv		24a. Was ar		b. Were auto	psy findings available
Ä	The la	E o	3020020		OII WA	<u> </u>	серпа	тора	city		autopsy	ed?	prior to cor death?	npletion of cause of
<u>ta</u>		Be C	25. Was case referred to medical						26 Place	ol Death	1 Yes 2	No	1 🗌 Yes	2L No
>	Attending Physician: The lav r death. ector: Alter this certificate has by the funeral director, page 2	10 E	examiner? 1 \(\text{Yes} 2 \(\frac{4}{2} \text{No} \)	Hospital:	nt 2 🗆 E	R/Outpatien	t 3 DC	Othe			me 5 ☐ Reside		Other (Specify	·)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	y Year)	28b. Time of Injury	2	28c. Injury Work	at		28d. Describe ho			·
0	uttendir death. ctor: Al y the fu	atic	2 Accident investigation				М		es 2□N	lo				
Division of Vital Records,	Il or Attend after death I Director: /	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At hor c. (Specify)	ne, farm, str	eet, factor	y, office		2	281. Location (Str. City or Town,	eet and Nur State)	mber or Rura	l Route Number,
a a	lospital of hours all uneral D												-	
	T 4 T 2	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best of ner: On the basis of	of my know examination	rledge, death on and/or inv	occurred estigation	at the time, in my op	e, date and inion, death	l place, a n occurre	and due to the ca ed at the time, da	use(s) and i te and place	manner as st e, and due to	ated. the cause(s)
	within 2 within 2 To the complet	Mec	29b. Signature and title of certifier	and manner sta	ued.			c. License					ned (Month, I	
}	- 3/2 8		10 K. Th.	1 Any	2				002602	24	23	_	1 11,	
	13/		30. Name and address of person who co	omnleted cause of d	eath (Item	23a) /Tuna	Print\					r	,	
Y(Lester Mile				,	oad.	Land	717 <i>0</i> 2	. MD 20	785		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra			· CI 1	Juu	шани	DVEL	با ک سند و	., 05		
133	Registr	ar .	APR 1 7 2006	eluc II.	200	W.								

xamir	al er	4a. Facility Name (If not institution, give	·		, Town, or Location of D		10, 2006 4c. County of De	ath
neral ector		100-36-1978			oitol Heic eri Year If Under 24 Days Hours N	drs. 8. Date of Bird (Month, Da June 8	Prince (h y, Year) 3, 1946 Ne	Georges inthplace (State or Foreign Country) EW York
in pa	or.	Usual Residence of Decedent 10a. State 10b. County	Cani	own or Location	ahts			10d. Inside City Limits 1 Yes 2 No
dical Examiner must be notified at	Director	MD Prince G	seorges Gap		ip Code		10g. Citizen of What C	Country?
	eral	4900 Heath Stre	12. Was Decedent Ever in U.S.		20743	(Specify Ves or No	United	
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		edent of Hispanic Origin? ecify Cuban, Mexican, Pi 2 No Specify:	rerto Rican, etc.)	Specify: B	ite, etc.
	Completed	15. Decedent's Edu (Specify only highest grad	lication 19 de completed)	6a. Decedent's Us (Give kind of w	ual Occupation ork done during most of use retired)	working	16b. Kind of Busines	s/Industry
	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		hier		CVS/I	Orug Store
	To Be C	17. Father's Name (First, Middle, Last) Raymond W. Ki	nard			Name (First, Middle, abeth Wi		
		19a. Informant's Name/Relationship (7) Shani Black (1)	10.		ss <i>(Str</i> eet and Number of vannah Tei			
	-	20a. Method of Disposition	l ceme	of Disposition (Na etery, crematory or	other place)	Date	20c. Location - City of	r Town, State
		1 ☐ Burial 2 ★ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Crem	vérdale atory	4/	13/06	Riverdal	
once.		21. Signature of Funeral Service Ucens	mcsi-X	22. Name a 1 4 0 9	and Address of Facility of Fairlakes	Snead's s Pl. Su	Mortuary iteB Mitchel	Service PA Wille,MD 2012
n .		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or con tion			ode of dying, such as car tic Carcir		rrest,	Approximate Interval Between Onset and Death Months
cal ier		resulting in death)	Due to (or as a consequent	ce of):				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence.	ce of):				,
	cal	resulting in death) Last	Due to (or as a consequent	ce of):				
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3□Ectopic			23d. Date of d Month	elive ry Day Year
		Part II. Other significant conditions co	ntributing to death but not resultin	g in the underlying	cause given in Part I.		obacco use contribute Yes 2∕2 No 3 ☐ F	to the cause of death? Probably 4 Unknown
	by					24a. Was	an 24b. Were a prior to death?	
	by				,	perfo	2 XNo 1 Ye	s 212 No
		25. Was case referred to medical examiner?				perfo 1 ☐ Yes Death (Check only o		
	To Be Completed by	examiner? 1 □ Yes 2 ▼No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/ 28a. Date of Injury (Month, Day Year)	b. Time of Injury	OOA Other: 4 Nursin 28c. Injury at Work?	perfo 1 Yes Death (Check only of g Home 5 XResid		
d in by the funeral director, page 2 should be detached for use as the	To Be Completed by	examiner? 1 Yes 2 No	1 Unpatient 2 LEN	b. Time of Injury M	OOA Other: 4 Nursin 28c. Injury at Work? 1 Yes 2 No	period 1 Yes Death (Check only company compan	dence 6 Other (Sp. now injury occurred	ecify)
ווי טץ ווום ועוופומו עוופכנטו, שמשפ ב אוסעום טם טפומכוופט זכו עצם מ	Certification; To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Phy	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify) resician: To the best of my knowletiner: On the basis of examination	b. Time of Injury M Injury M In farm, street, factor	OOA Other: 4 Nursin 28c. Injury at Work? 1 Yes 2 No ory, office	performance perfor	one) dence 6 □Other (Sp. now injury occurred Street and Number or I vn, State) cause(s) and manner	ecify) Rural Route Number, as stated.
	To Be Completed by	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify)	b. Time of Injury M M, farm, street, factor dge, death occurre and/or investigation	OOA Other: 4 Nursin 28c. Injury at Work? 1 Yes 2 No ory, office	period 1 Yes Death (Check only of g Home 5 X Resided 28d. Describe to the courred at the time,	one) dence 6 □Other (Sp. now injury occurred Street and Number or I vn, State) cause(s) and manner	ecify) Rural Route Number, as stated. Je to the cause(s)

DFIMH 17 Rev 1/2001

			For	State of Ma		d / Depa		Health a		•	ene	6	13618
			1 - State Registrar			Cei	rtificate c	t Death			g. No.	U	10010
	Physici	an	Decedent's Name (First, Middle, Last)							Date of Death Month	Day	Year	3. Time of Death
96	/Medic			. Kendall			4h Cihi Taua	n, or Location o		April		2006 by of Death	10:30P M
	Examin	er	4a. Facility Name (If not institution, give standardence Court		a 1 1	1.0	4b. City, Town			•			C 1 -
1 198	S Francis		5, Social Security Number 6. Sec			ast birthday)	If Under 1 Ye	ar If Under 2	sville 24 Hrs. 8.	Date of Birth			George's lace (State or Foreign
1	Funeral Director		579-03-0377]M 2 X)F	86	Yrs.	Months Da	ys Hours		(Month, Day, pr. 17			ash., DC
4.	PL .		Usual Residence of Decedent		40. 00	-							
	aryiar	_	10a. State 10b. County		TOC. City	y, Town or Lo	cation					1	0d. Inside City Limits 1 XYes 2 No
	he M	Director	DC 10e, Street and Number				10f. Zip Cod		ngton	10	g. Citizen of	What Cour	
	a or	ā	1811 Fort	Derrie Ct	C 1	r	101. Zip C00	200	120	1			
	ns 23	Funeral		12. Was Decedent E			Was Decedent			Yes or No-	14. Ra	ted St	an Indian,
10	r Iter	Fur	1 Never Married 2 Marned	Armed Forces?	lo	1			i, Puerto Rica	an, etc.)		ack, White, Af	_{etc.} rican
8	ral', o	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀	No Specify:			Spec	iry:	erican
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal thygiene. diother than "natural", or items 23a or 28a-f show event, the Medical Evanting must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			(Give	dent's Usual Oc kind of work do	ne during most	t of working	1	6b. Kind of	Business/Ind	dustry
2	han han	m	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use re						
5	Hygie Hygie ther t	ပိ	12th 17. Father's Name (First, Middle, Last)				Federa	1 Emp1o		irst, Middle, N		vernme	ent
and	d be f	o Be	William	Frazier						annah I		,	
<u> </u>	shoul mark math	2	19a. Informant's Name/Relationship (Ty			19b. Mailir	ng Address (Str	eet and Numbe				n, State, Zip	Code)
	nd 2 :		Elsie Frazier/D	aughter-i	n-Lav	w 18	11.Fort	Davis	St., 9	S.E. Wa	sh.,	DC 200	020
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at an once.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other	place)	Date	2	Oc. Location	- City or To	wn, State
Ĕ	Page nent ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Han	rmony l	Memoria	1 Park	4/17/2	2006	Lan	dover,	, MD
at	permit. Departr Imports any inj		21. Signatur of Funeral Service Licens	4	1-	22	2. Name and Ad	dress of Facility	y Stev	vart Fu	neral	Home	
Ш	805 g a		John .	Zewar	X, \bot	1		Benning				DC 20	
\$5).			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ne cause on each lir	10.			dying, such as	cardiac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			Arrest						
築	Examiner		1	Due to (or as			c Cardi	07/25011	ar Die	50250			
		ler	Sequentially list conditions, if any, leading to immediate	Due to (or as			c oardr	ovascui	ar Dra	case			
	outed od ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Diabe	tes 1	Mellit	us Type	2					
Ó,	te be executed ysicien end te burial-transit	Ex	resulting in death) Last	Due to (or as									
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x 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	nncv.							
Вох	aath c attend for us	ian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	Ideath 3[Ectopic pregna Other (specify					ate of delive Ionth	ory Day Year
o.	y the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	11110 01 0	5	_ ctrict (specify						
<u>a</u>	s that ned b	by Pr	Part II. Other significant conditions con	ntnbuting to death b	ut not res	ulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use co	ntribute to th	ne cause of death?
rds	w requires that been signed b should be det	o pa	Dementia,	Sacral de	cubi	tus ul	cer			1 🗌 Ye	s 2X No	3 🗌 Prob	ably 4 Unknown
Records,	aw re is bee 2 sho	plet							Ī	24a. Was ar			psy findings available inpletion of cause of
æ	The law	Completed								perform	ed?	death?	
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						of Death (C	heck only one	21	A	ssisted
of <	Physician: r this certifica ral director, p	2	1 ☐ Yes 2 🔀 No			ER/Outpatier	K 3L DOA			5 🗌 Reside			Living
n c	ling P	ion:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju- (Month, Day	y Year)	28b. Time o Injury		njury at Work? 1 □ Yes 2 □ I		. Describe ho	w injury occi	ırred	
Division	Attending ir death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ırv - At ho	ome farm st				Location (Str	eet and Nun	ber or Rura	il Route Number.
<u>S</u>	after after Dire	Certification:	4 Homicide determined	building, etc			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town	, State)		
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best iner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred at th vestigation, in r	e time, date an ny opinion, deal	id place, and ith occurred	due to the ca at the time, da	use(s) and nate and place	nanner as si , and due to	lated. the cause(s)
	to the ithin () o the comple	Me	29b. Signature and title of certifier	A -			29c. Lic	ense number		29	d. Date sign	ed (Month,	Day, Year)
	TH		1 Dando.	1 Trus	71	Δ		DC	9584		Anr	il 14.	2006
	Chin		30. Name and address person who ca	ompleted cause of d	eath (Iten	n 23a) (Type,	Print)			3			
	The		Barry Smit				rn Ave.	, SE #2	13, Wa	sh., D	C 200	32	
	Sta Registi		APR 1 7 2006	32. Registra									

			For State	State of Maryland	d / Department of H Certificate of		7	006 13619
(5)	Physici	an	1. Decedent's Name (First, Middle, La	st)	Certificate of	Death	2. Date of Death Month Day	3. Time of Death
8. 2.	/Medio	al	4a. Facility Name (If not institution, give Prince George		4b. City, Town, o	or Location of Death		2056 0057 M
	Funeral Director	**	5. Social Security Number 6. S		ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 3, 19	9. Birthplace (State or Foreign KENTUCKY
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND PRINCE 0		, Town or Location	my		10d. Inside City Limits 1XX es 2 ☐ No
	with the 3a or 28a	Direc	10e. Street and Number 3802 38th AVENUE		10f. Zip Code			zen of What Country?
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23a or 28a-f show important: If item 27 ie marked other then "natural", or iteme 23a or 28a-f show shiply or other traumatic event, it is Medical Examination notified at ancelling at an ancellin	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: WWII		dispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:WHITE
21215-0036	ithin 72 hc ne. nen *natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of workii	ng	nd of Business/Industry
	be filed w stal Hygier of other the	Be Cor	17. Father's Name (First, Middle, Last)	AUDITOR	18. Mother's Name	FEDE	RAL GOVERNMENT Sumame)
Maryland	2 should and Men le marke sumatic	၉	GUY D. KELLY 19a. Informant's Name/Relationship (Турө, Print)	19b. Mailing Address (Street	MYRTLE M and Number or Rura		r Town, State, Zip Code)
	1 and 2. Health ar am 27 le		LYNN W. GILLIAM	201 21	402 SOUTH MAIL			
more	Peges 1 nent of H int: If ita iry or ot	9	20a. Method of Disposition 1 Burial 2 Arcremation 3 4 Donation 5 Other (Specif	Ce.	ace of Disposition (Name of metery, crematory or other plants of LINCOLN CREMA	ce)		cation - City or Town, State FWOOD MARYLAND
Baltimore,	permit. Popartm Imports eny inju		21. Signature of Funeral Service Cel		22. Name and Addre	ss of Facility OLN FUNERA		
g's			23a, Part . Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	. Do not enter the mode of dyn	ng, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
100	/Medical		disease or condition resulting in death)	a. Arterios de Due to (or as a conseque	ence of):	traine 1	Heart Dis	case
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ence of):			
,092	ite be executed sysicien and ne burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	ence of):			
89				d				
	entifii ling p		IF FEMALE:	d				
.O. Box	the death certificat by the attending phy ached for use as th		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of decentions	death 3 Ectopic pregnance	y	2	23d. Date of delivery Month Day Year
о. О.	equires that the death certifi sen signed by the attending tould be detached for use as	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal of the second of t	death 3 ☐ Ectopic pregnance ath 5 ☐ Other (specify) _		23e. Did tobacco u	- 1
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			1 - For State Registrar	State of Ma	ryland /		nent of H cate of L		d Mental Hy	/gienę Reg. No.	2006	13620
			Decedent's Name (First, Middle, Last,)					2. Date of D	eath		3. Time of Death
	Physicia /Medic		Edward Jo	oseph	Kane	9			Month	21 Day	O Year	0945 "
	Examin		4a. Fecility Name (If not institution, give	4 .	TAL	4b.	- /.	Location of De			County of Deat	
	Funeral Director		5. Social Security Number 6. Se.	7. Age	(In yrs. last b		Inder 1 Year oths Days	If Under 24 H Hours M		9, 192	9. Birtl	hplace (State or Foreign
	and w.	}	Usual Residence of Decedent 10a. State 10b. County		10c, City, Toy	wn or Location	1					10d. Inside City Limits
	Maryla a-f eho	tor	MD Allegan	у		Cresapt						1 ☑ Yes 2 ☐ No
	with the s or 28s	Director	10e. Street and Number 13103 6th Avenue	CIVI		10	f. Zip Code	21505		10g. Citi	zen of What Co	untry?
	ns 23	Funeral	13 TU3 Ott1 Avenue	12. Was Decedent E	ver in U.S.	13. Was E	Decedent of Hi	spanic Origin?	(Specify Yes or N	0-	14. Race - Ame	
39	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f ehow Ita Medical Evanifier must ke notified at	<u>م</u>	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	。 WWII		es 2 No	n, Mexican, Pu Specify:	erto Rican, etc.)		Specify: wh	
S O	72 hou natura	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	168	a. Decedent's (Give kind o	of work done o	during most of v	vorking	16b. Ki	nd of Business/	Industry
12	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		orer	OT use retired)		PPG	3 Industi	ries
Maryland 21215-0036	al Hygi d other	BeC	17. Father's Name (First, Middle, Last)	17					lame (First, Middl			
yla	d Ment d Ment narked natice	2	Edward Bernard 19a. Informant's Name/Relationship (T)		10	No Mailing Ad	drans /Ctmat		Regina F			
	alth and 2 st		Patricia Herath	daugl		13105	6th Ave	enue SV	V Cres	apto		D 21505
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hypiene. Important: If item 21 is marked other than "natural," or items 23a or 28a-f show amportant: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.		20a. Method of Disposition 1 ☐ MSurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemet	of Disposition ery, crematory brose Co	y or other plac	e)	Date 4/22/200		esaptow	
Balti	permit. Departn Importa any injk		21. Signature of Funeral Service Licens	hell	1	22. Nan			Home, PA		MD 2150	2
			23a Part 1 Enter the disease, or complete shock, or heart failure. List only o	ications that caused ne cause on each lin	the death. Do	not enter the						Approximate Interval Between Onset and Death
}.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metasta			411 (81	1 Carcin	one of	-/111	75	1 Manh
	Examiner			Due to (or as a	consequence	e of):						
7	p ii	Iner	if any, leading to immediate	Due to (or as a	Consequence	e ut).						
.V	avecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	e of):						
8760,	ficate be executed physician and is the burial-transit	dical		d								
9	certific nding p use as t	у/Мес	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date of del	ivery
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth : 4□Pregnant at 9□Unknown			pic pregnancy er (specify)				Month	Day Year
S, D.	es that igned b	Ď	Part II. Other significant conditions co	ntributing to death bu	t not resulting	in the underly	ing cause give	en in Part I.				the cause of death?
òrd	w require been si should I	eted	Ovenang	Distery	DISE	950			24a. Wa	Yes 2		obably 4 □Unknown topsy findings available
Vital Records,	The law te has age 2 :	Completed	- ILIGHT	MAGNAC	7 7 4 6	y Lac x	7		- aut	opsy formed?	prior to death?	completion of cause of
/ital	ician: The certificate rector, pag	Bec	25. Was case referred to medical examiner?						Death (Check only			
	Physic this c	5	1 Yes 2 No	lospital: 1 Impatier 28a. Date of Injur	nt 2 ER/C	Outpatient 3[. Time of		4 Li Nursing	g Home 5 ☐ Re			cify)
ion	nding f ath. r: After e funer	atlon	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury N	28c. Injun Worl	k? Yes 2 □ No			,	
Division of	al or Attend a after death I Director: d in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, (Specify)	farm, street, fa	actory, office			(Street an own, State		iral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the tuneral director, page	Medical C		sician: To the best of iner: On the basis of and manner sta	examination a							
	To the within To the comp	Me	29b. Signature and title of certifier	nh	/	11	29c. Licens	e number		29d. Dat	e signed (Monti	h, Day, Year)
•			My	C (1)	usell	/	1	55	135		7/21	106
	6.	-	30. Name and address of person who c	ompleted sause of de	Auf (Item 23a	(Type, Print)	175	Pha	D. Cui	uho	Mone	mo
\$7. A	Sta		31. Date filed (Month, Day, Year) MAY 0 1 2006	32. Registra	s Signature	Joseph	,					
	Registi	rar	MINI O T COOL	A STATE OF THE PARTY OF THE PAR	-							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician APRIL 14 2006 10.45am HSUEH CHING LAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SPRING HOLY CROSS HOSPITAL SILVER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M 2□F CHINA 559 19 5291 Yrs. 82 Director FEB. 5 1924 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 U.S.A 1135 UNIVERSITY BLVD W #507 Was Decedent Ever in U.S. Armed Forces? Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ASIAN ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHEF PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be CHAN . SI MIN WOO $I_{i}AN$ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a HSUAN SHU LAN / WIFE 1135 UNIVERSITY BLVD W 507 S. S MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 permit. Page Department o Importent: if eny injury or once. 4/19/06 NORBECK MEMORIAL OLNEY MD 21. Signature of Funeral Service 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 12303 KAYAK DR UPPER MARLBORO MD 23a. Part1. Enter the disease, of can shock, or heart failure. List only mplications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBRAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I say leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physiclan and s the burial-transit Due to (or as a consequence of) Box 68760, by Physician/Medicai use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached for o 9 Unknown 9 ☐ Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 🗌 Yeş 2 No Attending Physician: : After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation i after death.

I Director: Aft
d in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide To the Hospital or within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 4/14/06 30. Name and address of person who completed cause of a ath (Item 23a) (Type, Print) ALAN R SEGAL MD,
31. Date filed (Month, Day, Year) 1519 HUGO CIR. SILVER SPRING MD 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

APR 1 4 2006

			For State Registrar	State of Maryland	d / Depa		lealth and N	lental Hyg	piene 06	13622
u _i			1. Decedent's Name (First, Middle, Las	1)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medio		WILLIE B.	LEE				April	6, 2006	4:41A M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Dea	
1			Southern Maryla	and Hospital	Cen,	Clinto	n		Prince	Georges
8.	6 Funeral		Social Security Number 6. Security Number		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Bir	thplace (State or Foreign
*	Director		207 32 1743	2 ^{M 2□F} 77	Yrs.		7.00.0	Nov-17	,1928 Flo	rída
	pu *		Usual Residence of Decedent 10a, State 10b, County	10c City	, Town or Lo	cation				10d. Inside City Limits
	eho eho	-		Georges Cli		Cation				1 ☐ Yes 2 🛣 No
	Ba-f	ecto		deorgeb cri		T 2: 2				
	with the Maryland a or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	a 23g	ra	6003 Sellner L			20735			USA	
	ifter death wi ir ttems 23a rifter must b	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	Yas Decedent of F Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	X Yes 2 □ No If Yes, Give Year or Dates:	,	☐ Yes 2M No	Specify:		Specify: B]	ack
8	within 72 hours after death with the Maryland ene. than "ratural", or items 23a or 28a-f ehow fas Madical Exartine matter notified at	edi	15. Decedent's Edi		16a Decec	lent's Usual Occur	nation		16b. Kind of Business	(Industry
15	in 72 n "n	Completed	(Specify only highest grad	de completed)	(Give		during most of work	ring	Tob. Wind of Edomocia	industry
212	filed with Hygiene. other than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	NCO				U.S. Arm	N.Z
D		BeC	17. Father's Name (First, Middle, Last)	\\			18. Mother's Nam	e (First, Middle,		. 7
<u>a</u>		To B	Caleb Lee, Sr.				Lottie	Mae Wi	lliams	
Maryland 21215-0036	and M		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street	and Number or Rui	al Route Number	r, City or Town, State, a	Zip Code)
	12 E d		Roxie V.Pillow	Lee/Wife	6003	Sellne	er Lane,	Clinto	n, MD 207	35
Baltimore,	s 1 ar		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of	ce) _	Date	20c. Location - City or	Town, State
Ĕ	Pages nent of I ant: If its ury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Ard	meter	n Natio	onal 4/14	/2006	Arlington	, VA
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens		22	. Name and Addre	ss of FacilityGre	ene Fu	neral Hom	ne, INC.
m	80 E 8		nelson a Str	un &	8	14 Fran	nklin St	reet,A	lexandria	,VA 22314
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cancer	11	1 na				Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consequ	ence of):	200				
	Examiner		Conventially list conditions	b						
		Пег	Sequentially list conditions, if any, leading to firm diate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	erice off-					
	nd rans	Examiner	that initiated events	С.						
760,	te be executed ysician and he burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):					
876	e K	lical		d						
(68	leath certificat attending phy I for use as th	Physiclan/Med	IF FEMALE:						1	
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy	y		23d. Date of del Month	ivery Day Year
<u>o</u> .	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5	Other (specify) _				Day Coar
9.	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as the		Part II. Other significant conditions co	ntobuting to death but not recu	Iting in the ur	adorhina oauco an	ron in Part I	23e Did to	bacco use contribute to	the cause of death?
of Vital Records,	signe	by		bstructue	-	A	1.00			obably 4 Unknown
0.0	w requir been si should I	etec		-	- 100	110011) (()	7		
Sec.	e taw has t	ompleted	cardor	yours.				24a. Was a autops	y prior to	topsy findings available completion of cause of
프		S						1 Tes	med? death? Y No 1 ☐ Yes	2 No
VIII.	Physician: This certifical	Be	25. Was case referred to medical examiner?	Hospital:		3□ DOA Otth	26. Place of Deat	h (Check only on	(e)	
of	× ∞ = 0	T0	1 Yes 2 No	1 Inpatient 200	R/Outpatien	3 DON	4 Nursing no		ence 6 Other (Spe	cify)
n	ling After une	lo	1 Natural 5 Pending	(Month, Day Year)	Injury	28c. Injur Wor M 1	yat rk? Yes 2 □ No	280. Describe no	ow injury occurred	
Sign	Attending r death. actor: After by the fune	Ica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	me farm stre		103 2 2 110	28f Location (St	treet and Number or Ru	ral Poute Number
=	p at F	Certification:	4 ☐ Homicide determined	building, etc. (Specify,)	et, lactory, office		City or Town		arai rioble ivalliber,
_	To the Hospital or Attention 24 hours after deatler to the Funeral Director: completely filled in by the	N C	29a. Certifier 1 Certifying Phy	sician: To the best of my know	vledge, death	occurred at the fir	me, date and place	and due to the o	ause(s) and manner as	stated.
	24 h 24 h e Fui	edical	(Check only 2 Medical Exam one)	iner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my o	ppinion, death occur	red at the time, d	ate and place, and due	to the cause(s)
	vithin To th	Me	29b. Signature and title of certifier	1		29c. Licens	e number	2	9d. Date signed (Mont	h, Day, Year)
			D AN	N		DI	16478		4706	
•	(4)		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type. I					
			Suresh A-Pa	telmo 7001	Sur	ratts R	el clin	Jose M	10 2073	ST
	Sta	te	31. Date filed (Month, Day, Year)	32. Pagistrar's Signat	ure	_				
	Registr	ar	APR 1 3 20	106 person	K A	and a				

06-02706 David R Levin

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Constitution of Pleatin and Mental Ply Registrer Certificate of Death	_	. No 200	6 13623
Physicia Medical Exami			Date of Death Month		3 Time of Death
Wieulcai Exaiiii	nei	David Reuben Levin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month April 21, 20	4c. County of Dea	1118 hrs
Towns .		2826 Dillon Street Baltimore			
Funeral Director		5. Social Security Number 218-80-5883	8. Date of Birth	(MM/DD/YYYY) 9 B -1973 Fore	irthplace (State or ign ountry) MD
any		Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location			10d Inside City Limits
*	'n	MD Baltimore			1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?
vith the Maryland 23a or 28a-f show notified at once.		2826 Dillon Street 21224 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Communication) 13. Was Decedent of Hispanic Origin (Specific Communication) 13. Was Decedent of Hispanic Origin (Specific Communication) 13. Was Decedent of Hispanication) 13. Was Decedent		USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No specify:	ecify Yes or No- Rican, etc.)	White, etc.	rican Indian, Black,
ours afi atural'	d by	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of wo	ork done	Specify: W} 16b Kind of Business	nite /Industry
6 172 ho an "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire	ed)		
within giene her th	omp	2 Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name ((First Middle Me		one Sales
21215-0036 ould be filed within 7 Mental Hygiene marked other than ic event, the Medica	BeC	Jeffrey Levin Annet		ckstein	
21, nould b id Men is mar tic eve	일	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ural Route Numb	er, City or Town, Stat	
MD and 2 sho salth and sm 27 is		Annette Levin - Mother 382 Beverly Ct., M 20a. Method of Disposition (Name of cemetery)		ne, FL 3	
Baltimore, permit. Pages I ar Department of Hes mportant: If ite njury or other tr		Burial 2 XCremation 3 Removal from State Carroll Cremations 04-	-24-06	Hampste	ead, MD
Balt permit. Departi Importinjury	Ш	21. g tu e of Funeral Service Licensee 22. Name and Address of Facility Eli	ine Fur	eral Hom	ne .
Physician	\dashv	MOO550 934 S. Main St., 23a Part Entwithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Narcotic and cocaine intoxication Due to (or as a consequence of):			Between Onset and Death
Same of the same o		Sequentially list conditions,			
	nine	if any, leading to immediate cause. Enter Underlying Cause C. Discourse in the base of the cause of the caus			
O, e be executed ssician and burial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
760, cate be executed physician and the burial - transi	Medical	X unpended ☐ AMENDED item#23a,27,28a-f,perME,g855,5/3/06	TT		
76 icat ph	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncv	23d. Date of deliver	y Day Y ear
Box 68760, e death certificate be the attending physic ed for use as the burned for use	nysicia	past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 1 Pregnant at time of death 5 Other (Specify) 9 Unknown		Niona	Day Teal
P.O.	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	the cause of death?
ords, w requir s been s should l	Completed		24a. Was an		utopsy findings available
Reco The law icate has	ошо		autopsy perform 1 ✓ Yes 2	ed? death?	completion of cause of es 2 No
Ital Reician: Th	انه	25. Was case referred to medical examiner?			es 2 No
F Vit	To B	1 V Yes 2 No Rospital 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing		esidence 6 🗸 Othe	r: Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death as Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	ation:	1 Natural 5 Deading (Month, Day, Year)	28d Describe ho ink	w injury occurred	
Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	Certification:		28f. Location (Stror Town, Sta	eet and Number or R te) 2826 Dill MD	ural Route Number, City on Street
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the cause(s) and manner as sta	rted
M21	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
No No		O.C.M.E.		April 22, 2006	
		30 Name and advess of person who completed caus of death (Item 23a) Mary G. Kipple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD	D 21201		
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 4 2006 32 Registrar's Signature			

		-	For State Registrar	State of Maryland / Depa	irtment of Health and Me tificate of Death	ental Hygiene	000 10064
			Decedent's Name (First, Middle, Las	:t)		2. Date of Death Month Da	3. Time of Death
	Physicia /Medic		Helenlou	Limber		Apr. 14	
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	40	. County of Death
			Harrison Senior		Snow Hill		Vorchester
	Funeral		5. Social Security Number 6. Se	⊓M a¥1∈	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	 Date of Birth (Month, Day, Yeer) 	
	Director		300-10-7484	92 Yrs.		pr 22,19	913 Washington
	and **	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Aaryl f sho	ō	DE Cuara	Dolman			1 ☐ Yes 2X No
	28a-	Director	DE Susse: 10e. Street and Number	x Delmar	10f. Zip Code	10g. Ci	tizen of What Country?
	with Se or				19940		USA
	ns 23	era	P.O. Box 308	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race · American Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28a-f show other treumetic event, Ita Madical Examinating the notilied at	by Funeral	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces?	f Yes, specify Cuban, Mexican, Puèrto F I □ Yes 2፟፟ሿ No <i>Specify:</i>	tican, etc.)	Black, White, etc. Specify: White
21215-0036	hour turel	pe pe	15. Decedent's Ed		dent's Usual Occupation	16b. h	Kind of Business/Industry
15	n 72 "nai	Completed	(Specify only highest gra	de completed) (Give	kind of work done during most of workin DO NOT use retired)	9	
12	withi ene. ther	mo	Elementary/Secondary (0-12)	College (1-4or5+) 2 Writ	or	Ne	ewspaper
	filed Hygi other ent,		17. Father's Name (First, Middle, Last)			(First, Middle, Maidei	
an	ld be ental ked c	To Be	William F.	Limber	Elva F	Pursley	
Maryland	1.2 should be filed within " h and Mental Hygiene. 7 is marked other then " ireumetic event, tha Meu	 	19a. Informant's Name/Relationship (7		ng Address (Street and Number or Rural		or Town, State, Zip Code)
Ž	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is eny injury or other treu		Dean W. Limber	r - Son 12 s	D Somerset Stre	et Cri	21819
ē,	s 1 a f Hea item othe		20a. Method of Disposition	20b. Place of Dispo			ocation - City or Town, State
Baltimore,	Pages nent of h ant: If its ary or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	remation 4/19	9/06 I	Ceola, PA
Ħ	permit. I Departm Importer eny inju		21. Signature of Fun al Service Licen	CC0442 22	. Name and Address of Facility		
ñ	permi Depar Impo eny ir		Kelet	Mary Be	eson Funeral Ho 153 Pulaski High	ome of New Way, New	ewark Wark, DF 19702
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not ent	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Denne en t	ia Alsheim	15 Ty	Onset and Death G-W-Carl
	/Medical		resulting in death)	Due to (or as a consequence of):	1	0,	7
	Examiner			h			
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	cuted nd ransi	Examiner	that initiated events	С.			
o,	an ar urial-t		resulting in death) Last	Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical		_ d			
9	artifica ing pl	Med	IF FEMALE:				
Box	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy	4	23d. Date of delivery Month Day Year
	that the death- ned by the atter detached for u	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		
P.0	d by	Phy		contributing to death but not resulting in the u	nderlying cause given in Part I	23e. Did tobacco	use contribute to the cause of death?
Division of Vital Records,	w requires that the been signed by th should be detache	l by	Tatti. Other significant contactions	on the burning to document of the burning of the bu	nuon, mg autor grant man ann	1 ☐ Yes 2	2 No 3 Probably 4 Unknown
Ö	need peen	Completed				24a. Was an	24b. Were autopsy findings available
3ec	40 60 64	mp			<u> </u>	autopsy performed?	prior to completion of cause of death?
<u></u>	Th afe pag					1 ☐ Yes 2 🔀 N	o 1 Yes 2 No
Vit	fing Physicien: n. After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death Other: 4 Aureign Hon		a Cather (Carrie)
of	Phys this ral di	1.	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatient 28b. Time of	IL 3 DOA 4 ANUISING HOI	ne 5 Residence	
U	fter	tlon	1 XNatural 5 ☐ Pending	(Month, Day Year) Injury	f 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No		
Si	Attending or death. ector: After by the fune	lca	3 ☐ Suicide 6 ☐ Could not b	e 28a Place of Injury . At home farm et	reet, factory, office		and Number or Rural Route Number,
≥	spitel or Attenious after deatlines level Director:	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town, Sta	te)
_	spite ours nerel	a C	29a. Certifier 1 Certifying Ph	nysician: To the best of my knowledge, deat	h occurred at the time, date and place, a	and due to the cause(s) and manner as stated.
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical	(Check only 2 Medical Examone)	miner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date ar	nd place, and due to the cause(s)
	o th Mithin Fo th	₩.	29b. Signature and title of certifier	0 242	29c. License number	29d. D	ate signed (Month, Day, Year)
			Som	LM, Pe	054422		14-14-06
	15		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print) Market St.	Poromas	ke MD 21851
	St	ate	31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (Type, RAL, MD, 1604- 32. Figistrar's Signature	barle		, , , , , , , , , , , , , , , , , , , ,
	Regist	rar	711 11 24 1	LUUU JAMAN NO 17			

				For State	State of	Marylan				d Mental H	ygiene	006	13625
				Registrar	/A)		Cer	tificate of	Death	2. Date of D	Reg. No).	3. Time of Death
	.28	Physici	an	Decedent's Name (First, Middle,		_				Month APRIL	Da		
4		/Medic		JEHU 4a. Facility Name (If not institution,	E.		NCH	JR.	or Location of De		14	4 2006 County of De	23:46 M
•	-	Examin		ATLANTIC G				•	LIN			WORCE	
		Funeral	1		6. Sex 7	Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of B	Birth Day, Year)	Q P	inthplace (State or Foreign Country)
	續	Director	X.	222-32-2520	1X M 2□F	59	Yrs.	Months Days	Hours M	DEC. 2	2, 19		MARYLAND
2		pg &		Usual Residence of Decedenf 10a. State 10b. County		10c. Cit	y, Town or Lo	ration					10d. Inside City Limits
7		lanyla ed	ō		ZEV								1 ☐ Yes 2 🛣 No
23:46		ith the Marylar or 28a-f ehow o notified at	Director	DELAWARE SUS	DEA		FRANK	10f. Zip Code			10g. Ci	tizen of What 0	Country?
,0		death with the Maryland ma 23a or 28a-f ehow I must be notified at	٥	33724 WILGUS	EMETERY R	CAD		199	45			USA	
		death ma 2	nera	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13. V			(Specify Yes or It erto Rican, etc.)	No-	14. Race - An Black, Wh	
2	90	after or its	Full	1 Never Married 2 🕅 Marrie		2 📉 No		Yes 2 No		eno rican, etc./		Specify:	
4	§ §	ural',	d b	3 Widowed 4 Divorced	Year or Da	tes:					1		WHITE
2	7-5-	n 72 h	Completed by Funeral	15. Decedent' (Specify only highest	grade completed)		(Give	ent's Usual Occu kind of work done OO NOT use retire	during most of v	working	16b. K	(ind of Busines	s/Industry
9.	12/	withir ene. then	d Ho	Elementary/Secondary (0-12) 12	College (1-	4or 5+)		TRUCTION	-,		C	CONSTRU	CTION
5	70	filled Hyg other	BeC	17. Father's Name (First, Middle, L	ast)				18. Mother's N	Name (First, Midd	le, Maider	n Sumame)	
1	lan	uld be Aenta rked tic ev	To B	JEHU I	E. L	YNCH	SR.		RACE	HEL	COLL	INS	
0	Mary	and the ma	. 5	19a. Informant's Name/Relationsh	ip (Type, Print)					Rural Route Nurr			
8	- 1	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ehov any injury or other traumatic event, tra Medical Examinar must be notified at once.		CINDY LYNCH/DA	UGHTER	205			R ROAD,	REHOBETI Date		CH, DE	
	$\mathcal{D}_{\!$	ges 1 if of H if Ita or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation		tate	emetery, cren	sition (Name of natory or other pla	1			,	
	Ę	it. Pa rtmer rtent njury		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		CR		OF DELN Name and Addre	-	/20/06	DE	LMAR, D	ELAWARE
0	Ba	perm Depa Impo any i		21. Signification of the control of	1 /	A			The Book and Albertain	HOME, SI	ELBYV	ILLE, I	E. 19975
7		ege - G		23a. Part. Enter the disease, or o shock, or heart failure. List of	complication that ca	used the deal	h. Do not ente	er the mode of dy	ng, such as card	dac or respiratory	arrest,		Approximate Interval Between
5		Physician		Immediate Cause (Final disease or condition	A 1 4	oschoo	tic Car	diovasur	lan Di	Scores			Onset and Death
Cit	2	/Medical		resulting in death)		or as a consec							
7	1	Examiner	_	Sequentially list conditions,	b		B						
à		led nsit	Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	n as a consec	uence on.						
7-		be executed ician and burial-transit	Хаг	that initiated events resulting in death) Last	c. Due to (c	or as a consec	uence of):						
2	8760,	cate be executed obysician and the burial-transit	dicall		d								
a	9		ledi										
	XO	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnath 2 Feta		Ectopic pregnanc	;y		1	23d. Date of d	
Ch	O. B	that the death ed by the atte detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregna 9☐Unknor	int at time of d wn	leath 5□	Other (specify) _				WORTE	Day Year
Lyne	ا م	that the		Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the ur	ideriving cause g	ven in Part I.	23e. Dio	d tobacco	use confribute	to the cause of death?
7	Vital Records,	Se Lo	d by	•	,			,,,		1 [Yes 2	. □No 3□1	Probably 4 Onknown
M	Ö	w require been si should I	Completed							24a. W	as an	24b. Were	autopsy findings available
2	Re	The lav	É							– au pe 1⊡ Yes	topsy rformed? 225 No	death	completion of cause of
Jehu	ta	ician: Th certificete ector, pag	BeC	25. Was case referred to medical examiner?	- 1			0.000.00	26. Place of D	Death Check on	-	,	2 2 140
7	of V	Physic this ce al direc	ToE	examiner? 1 ☐ Yes 2 ☐ No		,	ER/Outpatien	t 3□ DOA Ot	her: 4 🗌 Nursing	g Home 5 ☐ Re	sidence	6 ∐Other (Sp	ecify)
				27. Manner of Death 1 X Natural 5 ☐ Pending		f Injury n, Day Year)	28b. Time of Injury	28c. Inju		28d. Describ	e how inju	iry occurred	
	Sio	att :: e	icati	2 Accident investig	ot be 390 Place	of Injury - At h	omo farm etr	M 1 [Yes 2 No	28f Location	/Street a	nd Number or	Rural Route Number.
	Division	after after Direction by	Certification;	4 Homicide determi	hed buildin	g, etc. (Speci	(y)	ser, ractory, onice			own, Stat		iurai riodio ridinidoi,
		To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai C		Physician: To the lixaminer: On the ba	sis of examina							
		To th within To th compl	Me	29b. Signature and title of certifier	n			29c. Licen	se number		∠9d. Da	ate signed (Mo	nth, Day, Year)
		"D		11/1/20	rul	- (-	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	D2	8769		4	1156	06
		100		30. Mame and address of person v	chilen, a	D 620	.9 Co	Print)	lucy Fe	euwict-	Tolon	1, De	19944
	3	Sta Registi		31. Date filed (Month, Day, Year) APR 1 8	- M	egistrar's Sign	ature	arth)	(
	100			717 11 12 0			The state of the s	an Brown					

				artment of Health and Mental Hygier	
				etificate of Dooth	2008 12828
	1000	en:	Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
2 A	Physic /Medi	cal	Curtis Lyndell Matthews	April 6,	Day Year O. 45 7M
•	Exami	ner	Gladys Spellman Nursing Home		
	Funeral		5. Social Security Number 6. Sex 15. M 2 F 7.1 Vs.		rince George 9. Birthplace (State or Foreign Country) North
17	Director		Usual Residence of Decedent	June 18,	1934 Carolina
	death with the Maryland me 23a or 28a-f show Linust be nettilled at	_	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	the M 28a-f	Funeral Director	DC Washir		1∭Yes 2☐No
	with with	Ö	4000 P. C.L. C.	00045	Citizen of What Country?
	death me 2:	era	4002 E Street SE Apt. # 304 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No-	ited States 14. Race - American Indian.
336	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiane. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Markical Exprinter must be notified at	by Fur		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	Black, White, etc. Specify: Black
21215-0036	in 72 hou	Completed		ident's Usual Occupation be kind of work done during most of working DO NOT use retired)	Kind of Business/Industry
212	d 2 should be filed within 7 h and Mental Hygiene. 7 ie marked other than "r traumatic event, the Mad	E	Elementary/Secondary (0·12) College (1-4or 5+)		Private
b	e filec al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maid	
ylaı	Ment Ment arked	10	Guv Matthews	Virginia Marle	У
Maryland	2 short and in mand in manding		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and Number or Rural Route Number, City	y or Town, State, Zip Code)
	permit, Pages 1 and Department of Health important: if Item 27 any injury or other tr		Mrs. Flora Matthews/ Wife 4002 20a. Method of Disposition 20b. Place of Dispo	E Street SE # 304 Was	hington, DC
ğ	ages nt of t: if it		14 Burial 2 □ Cremation 3 □ Removal from State cemetery, crei	April 12.	Location - City or Town, State
Baltimore,	permit, Pa Departmen Important: sny injury		4 Donation 5 Other (Specify) MT . O1 i 21. Signalure of Edneral Service Licensee	vet 2006 Was 2. Name and Address of Facility Murray Fund	shington, DC
Ba	permit. Departrimports sny inju	6			gton, DC 20011
-46			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		week
	. 🕸	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	nsit	mine	cause Enter Underlying Cause (Disease or injury		
Ć	e be executed /sician and e burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):		
1760,	ite be iysicia o bur	cai	d		
89)	artifica ing ph e as th	Med	IF FEMALE:		
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	res that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Did tobacco	use contribute to the cause of death?
of Vital Records,	w require been sig should b	ed b	Arterio Sclerote Cardio	Vascular Divers 10 Yes	2 No 3 Probably 4 donknown
900	law requ as been 2 shoult	Completed	Dements of Artral Frynillan	on was Dugged 24a. Was an	24b. Were autopsy findings available
Ä		E C	Runingtony Failure Vestil	autopsy performed? 1 Poenulait 1 Yes 2 27	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
/ita	cian: ertific	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
of	Physician: rthis certificant	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a, Date of Injury 28b, Time of		
uo	g e	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury	f 28c. Injury at Work? M 1 Yes 2 No	jury occurred
Division	Atten deat octor; y the	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm str		and Number or Rural Route Number.
5	al or safter	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, Sta	fe)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	n occurred at the time, date and place, and due to the cause(vestigation, in my opinion, death occurred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number 29d. D	ate signed (Month, Day, Year)
	9		Challenles Ind Con	DO 1852 APR	126 2006
•	0		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	12 6, 2006 Sville MD 2078/
	'AGG		1 ml A. DEVURE, MD 42030	Weensbing Rd Myatt	Sville My 20781
	Sta Registr	2.0	APR 1 4 2006		

			For State Registrar	ate of Maryland / Dep Ce	ertificate of E	Death	Reg. N	.000	13627
k y	Physici		1. Decedent's Name (First, Middle, Last) Kathaleen Me	ercer			2. 3	ay Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give street of the Company of the Society Number	t and number) Hospe Tell 7. Age (In yrs. last birthday	4b. City, Town, or If Under 1 Year Months Days	Location of Death Location of Death If Under 24 Ms. 8. If Hours Min.	Date of Birth Month, Day, Yea	r) Coun	place (State or Foreign
wi.	Director		Usual Residence of Decedent	49 115.		4	/8/195	7 New	York
	anyland ahow	_	10a. State 10b. County	10c. City, Town or L				1	0d. Inside City Limits 1 ☐ Yes 2 XNo
	28a-1	Director	Md. Prince Geo	orges Capital	Heights		100.0	itizen of What Cour	
	3a or		1112 Larchmont A	ve.	20743	3		S.A.	, .
920	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28a-f ehow event, Ira Medical Examinat matter rediffed at	by Funerai	1 X Never Married 2 ☐ Married 1	Vas Decedent Ever in U.S. med Forces? ☐ Yes 2 M No Yes, Give 'ear or Dates:	. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: bl	
21215-0036	within 72 ho ene. then "natur	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)	opleted) (Giv Sollege (1-4or 5+)	edent's Usual Occupa e kind of work done d DO NOT use retired) emaker	uring most of working		Kind of Business/Ind	dustry
	filed with Hygiene other the		17. Father's Name (First, Middle, Last)	110111		18. Mother's Name (Fin			
/lan	should be filed and Mentai Hygi marked other matic event, I	To Be	Daniel Mercer			Willie	Mae	Davis	
Maryland	2 should and Men is marke		19a. Informant's Name/Relationship (Type, F	·		nd Number or Rural Ro			
Baltimore, N	Pages 1 and 2 should nent of Health and Mer int: If item 27 is marke ury or other traumatic		Bobby Mercer / Sc 20a. Method of Disposition 1 32Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	20b. Place of Disp cemetery, cre		Date 4/10/	20c.	Height Location - City or To delphi,	
Baltii	permit. Page Department of Important: If any injury or		21. Signature of Puneral Service Licensee	Marta	22. Name and Address			Mortuar shington	-
St.	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death)	ins that caused the death. Do not enuse on each line. Attacos clest				Disees	Approximate Interval Between Onset and Death
68760,	cate be executed physicien and physicien and the burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of): Due to (or as a consequence of):					
.O. Box 68	death certiff e attending id for use as	Physician/Medl	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
<u>α</u>	signed d be de	þ	Part II. Other significant conditions contribu	iting to death but not resulting in the	underlying cause give	n in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
Il Records,		Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ ↑	prior to con death?	psy findings available mpletion of cause of
of Vital	ician certifi rector	Be	25. Was case referred to medical examine? Hospi	tal:	ont 3 DOA Othe	26. Place of Death (C/	1		
	ding h. After fune	tion: To	1 - 105 2 NO	1 ☐ Inpatient 2 ☐ EP/Outpatie Ba. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury Work	4 Nuising Home	5 Residence Describe how in		1)
Division	o the Hospital or Attendi ithin 24 hours after death o the Funeral Director: A impletely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	Be. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office		Location (Street a City or Town, Sta	and Number or Rura te)	il Route Number,
	To the Hospital or within 24 hours after to the Funeral Direction of mpletely filled in the funeral birection of mpletely filled in the funeral birection of the funeral bi	Medical	(Check only 2 Madical Examiner:	n: To the best of my knowledge, dea On the basis of examination and/or i and manner stated.	ath occurred at the tim investigation, in my op	e, date and place, and inion, death occurred a	due to the cause(t the time, date a	s) and manner as sind place, and due to	ated. the cause(s)
	To th	Me	29b. Signature and title of certifier	11 +	29c. License			ate signed (Month,	Day, Year)
)	(1)		Alrador /	fregton Do	150	055927	Ba	ul 1/2	206
9	e		30. Name and address of person who comple		9, Print)		e Ma	ry low 1	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 4 2006	32. Registrar's Signature)), , , ,	

3k		1 - State Registrar 1. Decedent's Name	(First Middle	a. Last)		Ce	rtificat	te of l	Death		2. Date of De	Reg. No	UUU	3. Time of De
Physici /Media		Mary	M.	Miller							April		2006 ear	11:30
Examir	_	4a. Facility Name (If 7611 Woo	not institution dbine	give street and no Drive	umber)			Town, or ure1	Location o	of Death		P 4c.	County of Deat	eorge's
uneral irector		5. Social Security Nu 578-24-56 Usual Residence of	27	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs	. last birthday 3 Yrs.	If Unde Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bin Month, Da 6/3/1	1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 2 2 1 2	9. Birti Co Was	hplace (State or Fountry) h., D.C.
Sa-f ehow	Director	10a. State MD	10b. County			ity, Town or L	ocation							10d. Inside City L
Nor 2		10e. Street and Num		-				Code					izen of What Co	untry?
ne 23	eral	7611 Woo	odbine		cedent Ever in U	15 12		707	ionania Orio	nin2 (Cno	oifu Van as Na		S.A. 14. Race - Ame	does Indian
el', or iten Examiner	by Funeral	1 ☐ Never Marrie		Armed F	orces? 2 25 No ive	3.3.	If Yes, spe			, Puerto	ecify Yes or No Rican, etc.)		Bleck, White	e, etc.
in result and went rygener. If then 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Mudical Examinar must be motified at	Completed	(Speci		t grade completed,) (1-4or 5+)	(Give	edent's Usu e kind of wo DO NOT u	ork done d	turina most	of worki	ng	16b. K	ind of Business/	Industry
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and Mentel nygis le marked other aumatic event,	To Be	17. Father's Name (18. Mother		(First, Middle) Dyer	, Maiden	Sumame)	
ration and a	1	19a. Informant's Na	me/Relationsh	nip (Type, Print)		19b. Mail	ing Address	s (Street a	and Numbe	r or Rura	l Route Numb	er, City o	r Town, State, 2	lip Code)
if item 27 i		20a. Method of Disp	osition	en - Daug 3 □Removal from	20b.	Place of Disponentery, cre	osition (Na matory or d	me of other plac	Dr.,	Lau	rel, M		707 ocation - City or	Town, State
nlury		4 ☐ Donation 21. Signature of Fur			Ft	. Linc	oln C	em.	المراجع والمراجع	4-15	-06	Bren	ntwood, uneral	MD
Important: If its eny injury or ot		21. Signature of rui	me D	L. AL	aller				sburg				ood, MD	
/sician		23a. Part1. Enter th shock, or hear Immediate Cause (I	Final		caused the dea each line. ronic L					cardiac o	r respiratory a	rrest,		Approximate Interval Betwee Onset and Deal
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the attending thed for use a	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ☑ 9 □ Unknown	nonths?	1 Live	utcome of pregn birth 2 Fet mant at time of nown	aldeath 3[⊒Ectopic p ⊒ Other (s _t						23d. Date of deli Month	very Day Year
signed by the d be detached	δ	Part II. Other signific	cant conditio	ns contributing to o	death but not re	sulting in the t	underlying o	ause give	en in Part I.				_	the cause of death
s been si	olete										24a. Was	•	-	topsy findings avai
ate hes page 2	Completed	·	,								auto perfo 1 ☐ Yes	rmed2	prior to death?	ompletion of cause 2∐ No
is certificate director, pag	e e	25. Was case referre	ed to medical	Hospitali				100		of Death	(Check only	one)		
After this of	lon: To	1 ☐ Yes 2 ☑ N 27. Manner of Death 1 ☑ Natural	5 Pending	28a. Oate (Mor	Inpatient 2 [of Injury oth, Day Year)	28b. Time of Injury	of 2	28c. Injury Work	at	2	ne 5X Resi 28d. Describe		6 ☐ Other (Spec y occurred	ufy)
the	Certification:	2 Accident 3 Suicide 4 Homicide	investig 6 □ Could n determi	not be 28e. Plac	e of Injury - At h ling, etc. (Speci	nome, farm, st	meet, factor		Yes 2□N		28f. Location (City or To	Street an wn, State	d Number or Ru)	ral Route Number.
To the Funeral Directompletely filled in by	edical C	29a. Certifier (Check only one)	1⊠ Certifying 2 Medical B	g Physician: To th Examiner: On the tand man	e best of my kn pasis of examination stated.	owledge, deal ation and/or in	th occurred ivestigation	at the tim	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
To the Complet	Me	29b. Signature and t	tle of certifie	1 1)	296	c. License	number			29d. Dat	e signed (Month	, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09^{Day} Month 04 **Physician** 2006 6:20 P M Robert McLeod /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner P.G. Prince Georges' Hospital Cheverly 8. Date of Birth 07/12/1936 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1√ M 2□ F 69 Yrs. 244-44-4230 Director N. Carolina Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County Item 27 is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Bowie MD PG Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2009 Golden Morning Drive 20721 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13∑ Yes 2 □ No If Yes, Give Year or Dates: 61 - 64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) M.S. Teacher D.C. Public School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alvin Simmons Lillie Marie McLeod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ie m eny Injury or other traum once. Carrie S. McLeod - Wife 2009 Golden Morning Drive; Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran Cemetery 04/14/06 Cheltenham, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature & Fune at Service Ligens 5801 Cleveland Avenue; Riverdale, Maryland 20737 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or c shock, or heart failure. List or melications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tyone cause on each line. Immediate Cause (Final BLADDER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PROSTATE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physicien end detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Within 2 29b. Signature and tible of certifier 29d. Date signed (Month, Day, Year) 30. Nam addre s person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE LITTLE GLRY 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2006 Registrar

			1- For State of Maryland / Depart	ment of Health and Micate of Death		iene 006 136	30
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	Day Year	
	/Medic Examin		Thelma Louise Miles 4a. Facility Name (If not institution, give street and number) 4b.	c. City, Town, or Location of Death	April	16, 2006 6:06 4c. County of Death	_AM
1				pper Fairmount		Somerset	
	Funeral Director			Onths Days Hours Min.	8. Date of Birth (Month, Day, 02-06-1		or Foreign
	pur 🖈		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati		02 00 1		ia I imian
	Maryla f sho	jo				10d. Inside C	2 □ No
	th the	Director	MD Somerset Upper Fairs 10e. Street and Number	10f, Zip Code	10	Og. Citizen of What Country?	
	ath wil		8305 Fishing Island Road	21867		USA	
036	within 72 hours after death with the Maryland iena. r then "natural", or itams 23a or 28a-f show the Medical Examinat must be notified at	by Funerai	1 Never Married 2 Married 1 Yes 200 No If Yes, Give 1 3 Widowed 4 Divorced Year or Dates:	Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
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and	be filed ital Hygi id other evant, I	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name			
5		ဥ	Phillip Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Louise]		City or Tourn State Tie Code)	···
Mar	s 1 and 2 should if Health and Mar itam 27 is marke other traumatic			: 112, Upper Fair		MD 21867	
ore,	as 1 a of Hea fitam rothe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cremator	on (Name of		20c. Location - City or Town, State	
Baltimore,	permit. Pagas Department of Important: If it any injury or o		1 d □Donation 5 □Other (Specify) Miles Famil	Ly Cemetery 04/20		pper Fairmount, N	4D
g	permit. Departrimports any inj			ame and Address of Facility nman Funeral Home			
		/	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	o/3 Somerset Ave. ne mode of dying, such as cardiac o	r respiratory arre	ess Anne, MD 2185 Approximal Interval Bei	te ween
	Physician	V	Immediate Cause (Final disease or condition resulting in death) a. malignant	Sarloma		Onset and	Death
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8/60,	certificate be executed iding physician and use as the burial-transit	dical Ex	Due to (or as a consequence of):				
õ	rtificate ng phy as the	Aedic	U. TERMAN				
O. BOX	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ect 4 □ Pregnant at time of death 5 □ Ot	topic pregnancy her (specify)		23d. Date of delivery Month Day	Year
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Vital	Phyaician: Th this certificate ral diractor, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient :	26. Place of Death		nce 6 Other (Specify)	
ם ב		-	27. Manner of Death 12. Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1, Pending 1, Pendi			w injury occurred	
UIVISION	Attanding ir death. sctor: After by the fune	catic	2 Accident investigation	M 1 Yes 2 No	206 1		
<u>≥</u>		Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	City or Town	eet and Number or Rural Route Num , State)	iber,
	ne Hospital or n 24 hours afte ne Funerai Diri blately filled in I	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death oc my knowledge, death oc and manner stated. 1 Medicef Exeminer: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, a igation, in my opinion, death occurre	and due to the ca ed at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s	5)
	To the I within 2. To the I complat	ž	29b. Signature and title of certifier	29c. License number	29	Od. Date signed (Month, Day, Year)	
			C stegmen my	1) 25-19		4-17-06	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Charles D. Sterman was 30434 Wi	+VerninRd, P	rincess	Anne MD 218.	EZ
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 0 2006	•	,		
	Registr	ar	APR 2 0 2006 Steen &	needs!			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April T2 2006 Margaret Wilhelmina Muller 1:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Summerville at Westminster Westminster Carroll 5. Social Security Number 212-01-7215 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 12 Birthplace (State or Foreign Country) **Funeral** 1914 Days 1 M 2 X Hours 91 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Carroll MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Washington Road 21157 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2 No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry B. von Paris & Sons Elementary/Secondary (0-12) College (1-4or 5+) Board of Directors Moving and Storage Co other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil iment of Health and Mental H fant: If Itam 27 Is marked oth Jury or other traumatic even Bonaventure von Paris Theresa Anton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Wachter/sister 1075 Wilda Drive Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/1972006 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem Highlandtown, MD 21. Signature of Funeral Service Lice see Pricts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 (ANO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) Ass 2 ER/Outpatient 3 DOA this stor: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier (Item 23a) (Type Print) State **APR 13** Registrar

	1- State of N Registrer	Maryland / Depa <i>Cei</i>	artment of He rtificate of De	aith and iv e <i>ath</i>		giene () Reg. No.	06	13632
Physician /Medical	1. Decedent's Name (First, Middle, Last) George Howard McMurry				2. Date of De. April 8,	2006 2006	Year	3. Time of Death 7:00 A M
Examiner	4a. Facility Name (If not institution, give street and number Surburban Hospital	or)	4b. City, Town, or Lo	ocation of Death		4c. Coun	ity of Death	
Funeral Director	587–03–3464 ^{1☑ M 2□ F}	Age (In yrs. last birthday) 58 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Feb. 14,	^h 1948	9. Birthp Coun Missis	lace (State or Foreign try) SSippi
nyland show	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo Alexandria	cation				1	Od. Inside City Limits
or 28a-1 or 28a-1 or Directo	Virginia 10e. Street and Number 6102. Foresteen Dec	Alexardicia	10f. Zip Code			10g. Citizen o	f What Coun	1X Yes 2 □ No try?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Imperients of Health and Mental Hygiene. Institutely, or iteme 23s or 28s-1 show eny injury or other traumatic event, the Medical Examination must be exittled at once. To Be Completed by Funeral Director	6103 Larstan Dr. 11. Marital Status 1 Never Married 2 Married 12. Was Deceder Armed Force:	nt Ever in U.S. 13. \ s?	22312 Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	USA 14. Ri	ace - Americ ack, White, (
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiens 17 fe marked other than "naturel", or traumatic event, the Medical Example To Be Completed by F	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education	16a, Deced	dent's Usual Occupation	Specify:		Specification Sp	ity: White	[4
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yland 2 uld be filed Mental Hyg mrked other atic event,	17. Father's Name (First, Middle, Last) George H. McMurry		18	3. Mother's Name		Maiden Suma	ame)	
Mary nd 2 shou tith and M 27 le mar r traumati	19a. Informant's Name/Helationship (Type, Print) Rebecca McMurry — Wife		ng Address (Street and Arstan Dr. Ale				n, State, Zip	Code)
Baltimore, semit. Pages 1 ar Deperment of Jepen 1 ar mportent: If them any injury or other once.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetary, cren	natory or other place)	4-15-2	Date 2006	20c. Location	•	wn, State
Baltir Permit P Depertme Importer ony Injur	21. Signature of Poneral Service Licensa	22	Name and Address of 308 Backlick	of Facility Den		eral Home	e	
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CR (10)	30. Name and address of person who completed cause of		•			4/8/0	0	
State Registrar	Rohatgi Atul 9901 Medical C 31. Date filed (Month, Day, Year) 22. Regis	lenter Dr. Rod strar's Signature		20850		V		

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			Registrar		Ce	ertificate of			eg. No.	0 3533
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	ne Maryland Ba-f ehow	ctor			City, Town or L Annapol					10d. Inside City Limits 1 ☐ Yes 2√√No
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	/Medic	*	Carl R. Marsh								april	12	2006		-
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	s 1 and f Health item 27 other tr			ephew)	l aat	7923	Grace	Cir	ccle S	Seaf	ord. De				
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ij	tmen tant: jury		4 □Donation 5 □ Other (Specify		(Cremato			1				nar, De		
Baltimore,	permit. Peg Department Important: any injury c once.		21. Signature of Funeral Service Licen	. A \	4									oon F.H.	
	40=44	-	23a, Part1. Enter the disease, or com	- Non	nego						rel, De		9956	Approximate	
			shock, or heart failure. List only Immediate Cause (Final	one cause on eac	n line.									Approximate Interval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death)	a. M1	1000	cdial	infa	irch	g~					1 wk	
	Examiner			Due to (or	as a consec	quence oi):	7.445			1	diseas				
	4	ē	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consec	quence of):	- ca	an	Vasc	1160	diseas			years	-
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	•											
o,	exec en an rial-tr		resulting in death) Last	Due to (or	as a consec	quence of):									
8760,	ate be executed hysicien and the burial-transit	ical		d											
9	ng ph ng ph s as t	Med	IF FEMALE:			-						1			173
Box	eath certific attanding p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 ☐ Live birt			Ectopic pr	egnancy				2	3d. Date of del	*	
0	the des by the a tached fo	Physician/M	1 Tyes 2 No	4 ☐ Pregnan 9 ☐ Unknow		death 5	Other (sp	ecify)					Month	Day Year	
σ.	The lew requires that the death certificate hes been signed by the attanding plage 2 should be detached for use as to		Part II. Other significant conditions o	ontributing to deal	h but not re-	sulting in the u	nderhing o	auso dive	ne in Part I		23e Did to	bacco us	e contebute to	the cause of death?	_
Vital Records,	signe d be	d by										es 2		obably 4 Junknown	,
Š	w requir been si should	ete	Stroke	110001101	1100	Trope	Maun) ''	na ₄						
Rec	The lev cate hes page 2	Completed	failur	و							24a. Was a autop: perfor	sy		stopsy findings available completion of cause of	,
a		e Co	25. Was case referred to medical						00 81		1 ☐ Yes	2 ₽ No		2 No	
Š	Physician: r this certificaral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🖂 Inp	atient 2	ER/Outpatier	nt 3□ DC	Othe	000		Check only or ne 5 ☐ Resid		Other (See	a.6.1	
0	g Phy er thi		27. Manner of Death	28a. Date of	fnjurv	28b. Time o		8c. Injury Work			28d. Describe h			City)	
ion	nding lath. r: After e funer	atle	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	м		c? Yes 2 ∐1	No					
Division of	tai or Attendil s eftar death. bi Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of	Injury - At h	nome, farm, sti	eet, factory	, office		2	28f. Location (S City or Tow		Number or Ru	ural Route Number,	
ō	ital o rs eft rai Di led in	Ce													1
	Hosp 4 hou Fune ely fil	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the be	est of my knows of examination	owledge, deat	h occurred vestigation.	at the tim	ne, date and	d place, a	and due to the c	ause(s) a	and manner as	stated.	
	To the Hospital or Attending P within 24 hours eftar death. To the Funeral Director: After t complately filled in by the funera	Med	one) 29b. Signature and title of certifier	and manne	r stated.				number				signed (Mont		
	F.¥T.8	_	51-11/2				230		(1721					,	
	+ in		30 Name and address a	completed com-	of death (1)	m 22c) /T:-	Brien'	<i>ا</i> ر	المذاا			UL	1/13/0	6	
	1 mg		30. Name and address of person who	completed cause	or death (Ite	Yan I		Q.)	Sumo	T)/	2. Sp	م>د ر۵	1004 A	D 21804	
	Sta	te	31. Date filed (Month, Day, Year)	32. F	istrar's Sign	ature	1 10 10	,~	عدون ہوں	יוט	.)	10138		11804	
		ar	APR 172	006		N A	Land offi	9							

DHMH 17 Rev 1/2001

MARSH, CARL R

			1 - State Registrar	State of Maryland		irtment of H			giene Rog. No.	006	135	36
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith		3. Time of	Death
	Physici		Viola A Marin	01				Month	Day 14	2006	2:05	PM
	/Medio		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Dea	ath	-	ounty of Death		
	LAGITI	CI	Coastal Hospice	at the Lake		Salisbu	VU		I IA	licomic	0	
	Funeral		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year	If Under 24 Hi		h		place (State or	Foreign
	Director		214-10-6080	M 2½2 F 93	Yrs.	Months Days	Hours Mi	Sept. 2		12 Mar	v1and	
	ס		Usual Residence of Decedent						, ,	11.01	, Luiiu	
	ylan how		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City	y Limits
	Ma 	5	MD Wicomic	o Sa	lisbur	У					t x∑ Yes	2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?	
	within 72 hours after deeth with the Maryland ene. Than "natural", or itema 23a or 28e-f ahow In Madical Examinar munithe notilliad at	aic	351 Deer's Head H	ospital Road		2180)1			USA		
	999 E	Funerai	11. Marital Status	Was Decedent Ever in U.: Armed Forces?	S. 13. V	Vas Decedent of His	spanic Origin?	(Specify Yes or No- arto Rican, etc.)	14	. Race - Ameri Black, White,		
စ္	or its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		Yes 2√51No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		pecify:	Olc.	
2	ours rai'.	d by	3X Widowed 4 □ Divorced	Year or Dates:		2,44,110	Spec., y.			W.	hite	
, L	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa kind of work done d	uring most of w	orking	16b. Kind	of Business/In	dustry	
2	ithin	ldr.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired;		-				
7	filed w Hygier Sther th	ပ္ပ	12			Homema				Ho	ne	
ב	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden S	umame)		
<u>X</u>	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. Is marked other than "natural", or itema 23a or 28e-1 ahow aumatic event, the Madical Examination and the notified at	၉	Clayton W. Jones					ulah Whit			150	
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship (Typ					Rural Route Numbe	r, City or	Town, State, Zip	Code)	
	and ealth m 27			ughter)		4 Connel	Ly Mill		lmar,		1875	
altimore,	t. Pages 1 and 2 should by riment of Health and Mentariant: If item 27 is marked hiury or other traumatic en		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re		ace of Dispos emetery, cren	sition (Name of natory or other place	a)	Date	20c. Loca	tion - City or T	own, State	
E	permit. Page Depertment i Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify)	St.	Stephe	ns Cemete	ery Apr	11 17, 200)6 D	elmar,	Delawa:	re
<u></u>	Depertiment import in port in		21. Signature of Funeral Service License	θ		Name and Addres		mo.				
<u> </u>	20529		any Short	dewell	1	3 E. Grov	7e St.	Delmar,		9940		
			23a. Part1. Enter the disease, or complice shock, or theart failure. List only one	eations that caused the death e cause on each line.	. Do not ente	er the mode of dying	g, such as cardi	ac or respiratory arr	rest,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	MYOCA	RDIA	1- In	1FARC	TION PAILUR			Onset and D	eath
	/Medical		resulting in death)	Due to (or as a consequ	uence of):	,	,,,,,,	- 1				
П	Examiner		Sequentially list conditions.	CONGR	STIV	E HERD	AT F	AILUR	己			
	D =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):							
	cute	Examiner	that initiated events C.	DEMEN	UTIA							
o	e exe		resulting in death) Last	Due to (or as a consequ	ience of):							
8760	The law requires that the death certificate be executed ste has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dicai	d.									
9	ng pl	Med	IF FEMALE:									
Вох	eath certific ettending p	an/I	23b. Was decedent pregnant 23	3c. If yes, outcome of pregnal 1 Live birth 2 ☐ Fetal		Ectopic pregnancy			23	d. Date of deliv		
	s dea	sici	in the past 12 months? 1 □ Yes 2 No	4 Pregnant at time of de 9 Unknown		Other (specify)				Month	Day Y	'ear
o.	that the de led by the e detached f	Physician/Me	9 Unknowfi									
	igned be de	by	Part II. Other significant conditions conf	tributing to death but not resu	ılting in the ur	iderlying cause give	n in Part I.			contribute to t		
בַ	w require been sli should b	ted						1 T	es 2 🗩	No 3 □ Prol	oably 4 □U	nknown
ပ္ထ	e lawr has be je 2 sh	ple						24a. Was a	an	24b. Were auto prior to co	psy findings a	vailable
ž	The lite has	Completed					-	perfor	med?	death?	2 No	036 01
Vital Records,	ysician; The is certificate hi director, page	Bec	25. Was case referred to medical				26. Place of D	eath (Check only or	1			
>	lysical is ca direc	To E	examiner?	ospital: Copatient 2 1	ER/Outpatien	t 3 DOA Othe	1. 4 Nursing	Home 5 ☐ Resid	ence 6	Other (Specia	5 y)	
0	Attanding Physician; r death. sctor: After this certifice by the funeral director, I		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury	occurred		
<u> </u>	ittendir death. ctor: Af r the fu	atic	Natural 5 Pending investigation				es 2 □ No					
Division of	or Attuation of Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and . n, State)	Number or Run	al Route Numt	er.
	rs aft at Di	Ce										
	tospi una una siy fill	cal	29a. Certifier Check only 2 Madical Examin	icien: To the best of my know ar: On the basis of examinat	wledge, death	occurred at the tim	e, date and pla	ce, and due to the coursed at the time.	ause(s) a	nd manner as s	tated.	
	To the Hospital or Attending Phywibin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medic	one)	and manner stated.								
	5 1 5 P	2	29b. Signature and title of certifier			29c. License				signed (Month,		
,	M		, & Cu	nu		1000	52410		4	115/0	6	
	フ <i>"</i> "		30. Name and address of person who cor		23а) (Туре, і	Print)				4		0 0 1
			GHULAM WI	TRUS 2626	6 AT	rowi	0000	OT 84.	45%	JURY 1	140 2/2	50/
	Sta		31. Date filed (Month, Day, Yeer) APR 1 7 20	32. A gistrar's Signal	ture	nest.				,		
	Registi	ar	711 11 11 120	- PERCON	~ All	New C						

			For State Registrar	State of Ma		artment of Health and Nertificate of Death	lental Hygien	. U U D	13637
			1. Decedent's Name (First, Middle, Last	1)			2. Date of Death Month	ay Year	3. Time of Death
	Physicia /Medic		William Holl:	iday Murp	hy			6 2006	5:15 a M
1	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Death	4	c. County of Death	n
			4591 Bucktown I			Cambridge		Dorche	
	Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		nplace (State or Foreign untry)
	Director		215-26-3943 '' Usual Residence of Decedent	Z	76 Yrs.		Nov. 9, 19	929 Mar	yland
	and #		10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl f sho	ĕ	MD Dorche	ester		Cambridge			1 ☐ Yes 2 No
1	the 1288	Director	10e. Street and Number			10f. Zip Code	10g. C	Citizen of What Co	untry?
2	3e or		4591 Bucktown R	toad		21613		USA	
3	ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
21215-0036	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show Josal Exaculmer must be notified at	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give ' Year or Dates:	10	1 ☐ Yes 2 🗷 No Specify:	, mean, etc.,	Specify: Wh	
Ď	72 hours naturel', lical Exa	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dec	edent's Usual Occupation e kind of work done during most of work	ina 16b.	Kind of Business/I	ndustry
215	within 72 ho jene. r then "natur r e Maulcal	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	e kind of work done during most of work DO NOT use retired)			
2		Con	11			farmer		agricultu	ire
nd	be filed tal Hyg d othe event.	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Maide		
<u>yla</u>	D 2 2 0	은	William E. Murp	-			E. Brannock		F. O. 1.)
Maryland	and and ls rr		19a. Informant's Name/Relationship (7			ling Address (Street and Number or Rui			_
	s 1 and 2 f Health item 27 l		Florence Murphy 20a. Method of Disposition	wife	20b. Place of Disp	1 Bucktown Road, Consistion (Name of		MD 2161 Location - City or	
JO.	of of		1 Surial 2 ☐ Cremation 3 ☐		cemetery, cri	ematory or other place)			
Baltimore,	permit. Pag Department Importent: any injury c		'4 □ Donation 5 □ Other (Specify 21. Signat f Funeral Service License				1/19/06 Ca Thomas Fune		
Bal	pernit. Departe Importe any nju		I for I le	m		700 Locust St., Ca	mbridge, M		
ļΞ			23a. Part . Enter the disease, or composhock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not en	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	, M	yourdial	infarction			5 mantas
	/Medical Examiner		resulting in death)	Due to (or as	consequence of):	1			A
	Examine	L	Sequentially list conditions,		a consequence of):	heroscierosia			30 V
	bd sit	liner	cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequence of.				-
_	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				
8760,	be e								
587	phy:	edical		. d.					
Box	Physicien: The law requires that the death certific this certificate has been signed by the attending print director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at 9☐Unknown	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	ivery Day Year
P.0	at the de I by the a stached i	Phy	9 Unknown		A seed as a little of the Aber	and a binary and in Board	22a Did tohaca	a usa contributa to	the cause of death?
	quires that en signed b	by	Part II. Other significant conditions on	ontributing to death b	ut not resulting in the	underlying cause given in Part i.			obably 4 Unknown
Records,	The law requirate has been apple 2 should	Completed	.,,				24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of 2 No
Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical			26. Place of Dea	th (Check only one)		
f V	nysic nis ce direc	10 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpati	ent 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐ Other (Spec	cify)
n of	ding Physicien: After this certific funeral director,		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	Work?	28d. Describe how in	jury occurred	
Sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1 Yes 2 No	COL Landing (Charact	and Mumber of O	and Courts Alambas
Division	el or Attendes safter deatl	Certification:	4 Homicide determined	286. Place of inj	ury - At home, farm, s c. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta		irai nodia Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	ro th within Fo th	Me	29b. Signature and title of certifier	1.11	///	29c. License number	29d. [Date signed (Monti	h, Day, Year)
)	- >- 0		D () / V	UIX	1 - M	D50804	L	1-17-06	,
			30. Name and address of person who	completed cause of d		a Print)			
			Mark Malkus,	MD. 408	Byrn Stra	set Cambridge, N	W 31012	3	
	Sta Regist	ate rar	31. Date filed (Month Day, Year)	006 32. Sigistr	ar's Signature	hade			

State of Maryland / Department of Health and Mental Hygiene | | For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** APRIL 13, JUANITA NELSON 2006 1855 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE HOSPITAL CHEVERLY PRINCE GEORGE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JULY 22, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🔀 F 252-38-1017 75 Yrs. 1930 GEORGIA **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Worle r then "naturel", or iteme 23s or 28s-f ehov tre Medical Examinat must be notified at MD PRINCE GEORGE LARGO 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 500 N. HARRY S. TRUMAN DR. 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No ģ 3 X Widowed 4 □ Divorced ted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Comple College (1-4or 5+) 2YRS Elementary/Secondary (0-12) LABORER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filt iment of Health and Mental Hi tant: If Item 27 is marked oth THOMAS BROWN LUCINDA GIBBS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 500 N. HARRY S. TRUMAN DR. LARGO, MD 20774 DIANE V. NELSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. - 5 CALVERTON NATIONAL 4/20/2006 CALVERTON, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME21. Signature of Funeral Service Licensee D 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY HYPERTENSION MONTHS /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: 957 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□ Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2/2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 🖾 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the trive, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) nd title of cedifier To mos 29b. Signature 4/14/2006 13 D32261 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RICHARD J. FELDMAN, MD 9500 ANNAPOLIS RD LANHAM, MD 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2006 Registrar

			For State Registrar	State c	f Marylar				lealth a <i>Death</i>		lental Hy	giene Reg. No	00)	136	39
			1. Decedent's Name (First, Middle, La	st)							2. Date of De		v \	/ear	3. Time	of Death
	Physici /Medio													9:4	40 P M	
	Examin		4a. Facility Name (If not institution, give	e street and nu	mber)		4b. Cit	y, Town, o	r Location o	of Death		4c.	. County of	Death		
			Casey House				Rock	vill	e			Mo	ontgo	nery		
	Funeral		Social Security Number 6.5	Sex I□M 2[X]F	7. Age (In yrs.	last birthday)	If Und Month	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth av, Year)		Birthpl Coun	ace (State	e or Foreign
	Director		212-62-1052	1 M 2 LAN	4	43 Yrs.	, , , , , , , , , , , , , , , , , , ,				Sept 9	, 19	962 1	New	Jerse	≥ у
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											10	od Inside	City Limits
	aryla eho	۱ ـ	Tou. State				, cuttori							''		es 2 No
	Sa-f	octo	Maryland Montgome	ery	Dama	ascus	1.00					400				X
	with t	盲	10e. Street and Number					ip Code				-	tizen of Wh	at Coun	try ?	
	hours after death with the Maryland ture!, or tteme 23a or 28a-f ehow al Exeminat must be notified at	Funeral Director	24721 Ridge Road	10 Mas Das	edent Ever in U	10 12	208		l'	ining (Co.		USA	14. Race	Amaria	an Indian	
	er de men	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo	orces?		was Dec	ecify Cub	an, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	-		White,		
36	rs aft	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve		1 🗆 Yes	2 🛚 No	Specity:				Specify:	Whi	te	
21215-0036	ture		15. Decedent's E					ual Occup	ation			16b. Kind of Business/Industry				
15	within 72 ene. then "nai	Completed	(Specify only highest gr		kind of work done during most of workir DO NOT use retired)			ina		Lthca	re I	nfori	mation			
2	iene iene the	E O	Elementary/Secondary (0-12)	College (4	1-40r 5+)	DNA Me	edica	al In	forma	tion	Proces	i				
	Hygie other	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle	, Maiden	Surname)			
a	2 should be filed within 72 hours after death with the Marylan and Menial Hygiene. Is marked other then "naturel", or iteme 23a or 28a-1 show eumatic event, Ita Medical Examinar must be notified at	To B	Robert David Brown Kare								len Sno	now				
altimore, Maryland	shou od N mar		19a. Informant's Name/Relationship (Type, Print) Step 19b. Mailing Address (Street and Number or Rural Route N									nber, City or Town, State, Zip Code)				
	od 2 alth a 27 lo		Parke Lewis Brown	ı, Jr./	Father	11804	4 Cha	aren	Lane	Poto	mac, MI	208	.0854			
	es 1 and 2 should b of Health and Ment fitem 27 le marked r other treumatic e		20a. Method of Disposition	20b. Place of Dispo				sition (Name of patery or other place) Apr:			I 18,	20c. L	c. Location - City or Town, State			
Ë	Pages nent of int: If it iry or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		esapeal				20		Be1t	svil	le.	MD		
를	permit. Pages Depertment of Important: If it eny injury or o		21. Signature of Funeral Service Lice	nsele /	11	22	2. Name	and Addre	ss of Facilit	tv						
m	Ped		Bors Lity	Lill	to MO	GC 1251 Ra	ing	Home	Crem	atio	n Servi	ce C1a	P.O.	Box ille	784 - MD	21029
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between													nate
	hysician		Immediate Cause (Final													d Death
	/Medical		disease or condition resulting in death)		Cell (or as a consec		oma									
П	Examiner					,,.										
		je	Sequentially list conditions, Tarry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Cause (Disease or injury that initiated events C.													
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ó	exec en an rial-tr	EX	resulting in death) Last Due to (or as a consequence of):													
8760,	icate be executed physicien and the burial-transit	dicai														
89																
ŏ	death certif e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		Tectonic	oregnancy	,				23d. Date			
.O. Box	deat e att	icia	in the past 12 months? 1										Month Day Year			
о. О	by th	hys	9 Unknown													
	The law requires that the death certif vie has been signed by the attending page 2 should be detached for use a:	by	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	nderlying	cause giv	en in Part I		23e. Did 1	23e. Did tobacco use contribute to the cause of death?				f death?
Division of Vital Records,	w require been sign		1 Yes									Yes 2	s 2 ∰No 3 ☐ Probably 4 ☐Unknown			
o O	s be	Completed									24a. Was	an	24b. Were autopsy findings available prior to completion of cause of			s available
Ä	The lav	E							-			ormed?	de	ath? Yes		Cause of
ta		0	25. Was case referred to medical	1 ☐ Yes 2 26. Place of Death (Check only one									, , , ,			
<u>-</u>	Attending Physician: r death. ector: After this certifice by the funeral director, i	To B	examiner? 1 ☐ Yes 2 🔀 No	14 itali							me 5 ☐ Resi	idence	6 🖰 Other	(Specify	Hosi	nice
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury				28c. Injur Wor			28d. Describe				1100	
ō	ath. r: Aff	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		,, ,,	,,	М		Yes 2□	No						
<u>S</u>	or Attendate death Director:	1112	3 ☐ Suicide 6 ☐ Could not to determined	28e. Plac	e of Injury - At h	nome, farm, str	eet, fact	ory, office			28f. Location (City or To			or Rura	Route No	umber,
ō	Hospitel or 24 hours afte Funerel Dir tely filled in	Certification:														
	Hospitel	cai	2 is Certifying Pl (Check only 2 Medical Exa	hysician: To the	e best of my kn	cwladge, deat	h oneum	d at the ti	ne, date an	id plane	and due to the	caue (e) and man	ver as et	the cours	9(6)
	To the Hospitel or Atten within 24 hours after deat to the Funerel Director: completely filled in by the	edicai	one)	and mar	ner stated.	andri androi in				an occurr	ou at the time,					
	To the within 2. To the I complet	Σ	29b. Signature and utle of certifier				2	9c. Licens	e number			29d. Da	te signed (Month, I	Day, Year,)
					MI	>		3563	5			Apr	il 17	, 20	06	
2	az	- 13	30. Name and address of person who													
1			Joseph Kaplan, M				i11 :	Rd. R	ockvi	11e,	MD 208	355				
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Sign	ature	-									

			For State Ragistrar	State of Mary		artment of F rtificate of			giene 006	13540			
	Physici	an	1. Decedent's Name (First, Middle, Last	")				2. Date of Dea Month	ath Day Year	3. Time of Death			
	/Medic	al	ROSE BOTTEON 4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of D	APRIL	23 2006 4c. County of Dea	6:02 p			
	Examin	er	Union Hospital			Elkto			Ceci1				
	Funeral		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt	h 9. Bi	rthplace (State or Foreign			
	Director		210-09-4597	□ M 2½F 8	5 Yrs.			Mar 31		nnsylvania			
	iand ow		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits			
	affect	tor	MD Cecil		Earlevi	i11e				1 ☐ Yes 2 1 No			
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?			
	eath w	eral	185 Midway Dr	12. Was Decedent Ever	in II S 13	21919 Was Decedent of h		2 (Specify Yes or No	U.S.A.	encan Indian, -			
' O	r item	Fun	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give				? (Specify Yes or No ruerto Rican, etc.)	Black, Wh	ite, etc.			
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow the Madisal Exemplar must be multified at	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	White			
5-0	"natu	Completed	15. Decedent's Edi (Specify only highest grad		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of d)	working	16b. Kind of Business	s/Industry			
12	iene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	-/		Own Home	۵ .			
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "natural", or iteme 23a or 28a-f show of other then "natural", or iteme 23a or 28a-f show svent, the Medical Examination in the baroutified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,					
Maryland	should be and Menta i marked umatic sy	T _O	Pietro Botteor					oria De					
Mar	d 2 sth ar		19a. Informant's Name/Relationship (T		10000	x ee			er, City or Town, State,				
	s 1 an f Heal item 2 other		20a. Method of Disposition	1	0b. Place of Dispo			Fallston Date	MD 21 (20c. Location - City o				
<u>m</u>	Page nent o int: If iry or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		*	of Fait		/28/06	Baltimore	e, MD.			
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 eny injury or other 900.		21. Signatur of June at S. rvi Lie n	1/	Ga	2. Name and Addre alena Fu 18 West	neral	Home of	Stephen ena, MD.	L. Schaech			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	death. Do not en	ter the mode of dyi	ng, such as car	rdiac or respiratory ai	rest,	Approximate Interval Between Onset and Death			
1 8 %	Physician		Immediate Cause (Final disease or condition resulting in death)	. INTRACK	PANIAL	- HEMM	NORRH	IAGE		Oliset and Death			
	/Medical Examiner		f	Due to (or as a co	nsequence of);								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
A	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	be exician a	ical Ex	Tesuting III deathly East	Due to (or as a co	nsequence ot):								
687	ficate physis	edica	•	d									
Box (death certifica e attending ph id for use es th	In/M	23b. was decedent pregnant	23c. If yes, outcome of p		□Ectopic pregnanc	24		23d. Date of de				
	the att	Physician/M	in the past 12 months? 1 □ Yes = 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐ Unknown		Other (specify)			Month Day Year				
P.0	= >0		Part II. Other significant conditions co	ontributing to death but no	ot resulting in the (underlying cause gr	ven in Part I.	23e. Did t	tobacco use contribute to the cause of death?				
ecords,	8 <u>6</u> 8	d by						1 🗆 '	1 Yes 2 No 3 Probably 4 Winknown				
000	aw requii as been s 2 should	Completed		24a. Was									
Œ	The ate h	Com				perfo	rmed? death? 2☑No 1☐Ye	_					
Vital	Physician: T this certificat ral director, p	Be	25. Was case referred to redical examiner?	Hospital:		i Ot	her	Death Check only					
of	Phys r this ral din	.: To	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatie	III 3 DOA	4 Nursi		dence 6 Other (Sp	ecify)			
ion	Attending Prdeath.	atlor	1 L atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury		ork?]Yes 2 □No		200. Boschoo How injury occurred				
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, si	reet, factory, office		28f. Location (. City or To	Street and Number or F vn, State)	Rural Route Number,			
	Hospitel or 4 hours afte Funerel Dir tely filled in		200 Contition 1 Total tributing Ph	ysician: To the best of m	v ka swiedan den	th conversed at the t	in a laborated	alone and due to the		- stated			
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one) Certifying Physics Check only 2 Medical Example one)	niner: On the basis of exa and manner stated.	amination and/or in	nvestigation, in my	opinion, death	occurred at the time,	date and place, and du	ue to the cause(s)			
	To th To th comp	Me	29b. Signature and title of certifier	171			se number		29d. Date signed (Mor				
			1-EUNCE		10		00634	86	APRIL,23,	2006			
	5		30. Name and address of person who of M.A. HAMADE	H Unio	n Hospi	tal 106	Bow :	St. Elkt	on, MD. 2	21921			
de d	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 1 20	34 Registrar's	Signature	whi				•			

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death	and Me	ental Hyg	giene () Reg. No.	06	13641	
۳	Physici	an	1. Decedent's Name (First, Middle, Las		_						2. Date of Dea Month	Day	Year	3. Time of Death	
	/Media	al	Catherine rendarvis					Town or	Location o		April		2006 inty of Death	2:15 P ^M	
65	Examir	ıer	Prince Georg				40. 0.0,		Cheve					eorge's	
	- Funeral		Social Security Number 6. Security Number		. Age (In yrs.		If Under Months		If Under 2	_	8. Date of Birth		9. Birthp	lace (State or Foreign	
	Director		3.0	1 M 2 XF 68 Yrs.				Days	Tiours	J	8. Date of Birti (Month, Day uly 9,	1937	1937 Wash., DC		
	land land		Usuaf Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	Od. Inside City Limits	
	Mary Ff sh	to	Maryland Prince G	eorge's				Rive	erdale	2				1X Yes 2 □ No	
	th the	Jirec	10e. Street and Number				10f. Zip					10g. Citizen	of What Coun	try?	
	ath wi	rai	6213 Kenned						207				nited		
	itema itema	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dece Armed For 1 ☐ Yes	ces?	I.S. 13.	Was Deced If Yes, spec	dent of Hi offy Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto P	cify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,		
036	urs af	by F	3 X Widowed 4 ☐ Divorced	If Yes, Give			1 🗆 Yes	2K) No	Specify:			Spe	ocity: B	lack	
5 O	filed within 72 hours after death with the Maryland Hygiene yther than "natural", or itema 23a or 28a-f show yth, it a Mudical Exam act must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation		16a. Deced	dent's Usua	al Occupa	ition uring most	of workin	a	16b. Kind o	f Business/Inc	lustry	
2	han "	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)			DO NOT us	se retired,)	0	9				
7	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle,	Maiden Sun	Private		
Baltimore, Maryland 21215-0036	id be entai ked o	To Be													
ary	shou and M s mar	-	ROBert C. Lindsey Alice Heath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town										wn, State, Zip	Code)	
Σ.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Mudical Exprit set must be notified at another.		Arlievia Pendar	vis/Daug		62	13 Ke	nned	y St.	, Ri	verdale	e, MD	20737		
ore	ges 1 t of H if Itea or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from S	tate	cemetery, cren	natory or o	ther place	9)						
	t. Pa rtmen rtant;		4 ☐Donation 5 ☐Other (Specify 21. Signature of Funeral Service Ligen:)	нат	mony M			ark 4		2006 Stewart		andove:	•	
Ba	Depariminant in moon in		Quant Light	Sterion	X-TII						., NE				
	8 8	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between		
	Physician												Onset and Death		
## T	/Medical Examiner		resulting in death) Due to (or as a consequence of):												
	LAdillilei	_	Sequentially list conditions,	b. Due to (s	Due to (or as a consequence of):										
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a conseq	juence or):										
C,	exectin and ial-tra	Еха	that initiated events resulting in death) Last	Due to (c	r as a conseq	juence of):									
8760,	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	· ·	d											
39 ×	ertifica ling pt e as tl	Med	IF FEMALE:						<u> </u>						
О. Вох	attenc for us	Physician/Me	in the past 12 months?		ome of pregna th 2 ☐ Feta nt at time of d	il death 3 □	Ectopic pr						Date of delive Month	ry Day Year	
o <u>i</u>	the de y the	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	өспу)			·	33,							
ري ص	s that ned b e deta	by Pt	Part II. Other significant conditions co	ntributing to de	ath but not res	ufting in the ur	ndertying c	ause give	n in Part I.		23e. Did to	bacco use c	ontribute to th	e cause of death?	
ğ	w require been sig should b											es 2□No	3 ☐ Proba	abiy 4 🗷 Unknown	
မင္ပ	e law re has be ge 2 sho	Completed			24a. Was a	an 24	24b. Were autopsy findings available prior to completion of cause of								
		Con									perfor	med? 22 No	death?	2 □ No	
<u> </u>	sician certifi rector	Be	25. Was case referred to medicat examiner?	Hospital:		/		Othe	-		(Check only or				
Division of Vital Records,	Phys or this oral di	. To	27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of		8c. Injury Work	4 🗀 1401		e 5 Resid)	
<u>o</u>	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	Injury	м		? ′es 2 □ N		28d. Describe how injury occurred				
<u>S</u>	or Attending I after death. Director: After in by the funer	Certification;	3 Suicide 6 Could not be determined								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
۵	oital ours aff									1					
	Hospital 24 hours Funeral	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the l iner: On the ba: and∳nann	sis of examina	wledge, death ition and/or inv	occurred estigation,	at the time in my op	e, date and inion, deatl	d place, ar h occurre	nd due to the c d at the time, c	ause(s) and late and plac	manner as sta e, and due to	ited. the cause(s)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Me	29b. Signature and title of certifier	//			290	. License	number				ned (Month, L		
	9		1	how			1	58	795	7		4 -	14-01	le constitution of the con	
	Voic		30. Name and address of person who co					No	, -)	n	HEVERLY	A / 7	200	10 -	
	92		DR GARY LITTLE 31. Date filed (Month, Day, Year)		gistrar's Signa	OSPITA	1	UK		4	HEVERLY	1 141	ou,	85	
	Sta Registr		APR 1 7 2006	Leve D	k L	رياه									

			1 - State of Maryland / I	Department of Health and N Certificate of Death	Mental Hygiene 🕦 🗍 (5 13642
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Y	3. Time of Death
	Physici /Medio		Richard Wyndon Perkins		April 10, 2006	9:20 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of	
			Anne Arundel Medical Center	Annapolis thday) If Under 1 Year If Under 24 Hrs.	Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 21,1931	Birthplace (State or Foreign Country) Idano
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	Maryi f sho	ō	MD Anne Arundel Anr	napolis		1 ☐ Yes 2 📉 No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	at Country?
	th with	аіD	84 North Old Mill Bottom Rd.	21409	USA	
	ltams	Der	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	American Indian, White, etc.
36	hours after tural; or Ita	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 🕅 No Specify:	Specify:	
Ö	n 72 hours *natural',	d D	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a	Decedent's Usual Occupation		White
5	in 72	ojet	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Busin	less/illoustry
212	d within jiene. ir than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Lawyer	U.S. Gov	rt.
b	be filed within tal Hygiene. d othar than * evant, Ire Me.	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Sumame)	
ylaı	ould be Mental arked o	To	Martin Perkins	Fay Cr	anney	
Maryland 21215-0036	2 sh and and ls m	0.4		. Mailing Address (Street and Number or Run		ate, Zip Code)
	s 1 and of Health itam 27 other tr				wie, MD. 20715 Date 20c. Location - Ci	h, or Town State
آور	e = = 5		1 Burial 2 X Cremation 3 Removal from State	Disposition (Name of ry, crematory or other place) olitan Crematory 04/1		
Baltimore,	permit. Pages Department of I Important: If its any injury or of		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenser		all Funeral Home	
Ba	Depa Impo any ii		Chuan towall	6512 NW Crain Hwy.	Bowie, MD. / 20	715
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest.	Approximate Interval Between Onset and Death
	Enysician		Immediate Cause (Final disease or condition resulting in death) a. Respiratory Ar	rrest	900	9 0.1301 4.13 554.11
	/Medical Examiner		Due to (or as a consequence Aspiration of		NO 10	
		e.	Sequentially list conditions, if any, leading to infinediate		A A V	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	() 0,0	Byl, M,	
o,	be execu ician and burial-tra		resulting in death) Last Due to (or as a consequence	of):	My W	
8760	0 5 0	dicai	d		1	
89 x	certificat nding phy use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of	of delivery
Вох	atten 1 for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month	,
P.O.	res that the designed by the a	hysi	9 Unknown 9 Unknown			
	requires that the een signed by th tould be detache	by P	Part II, Dther significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco use contribu	
ord	v require been sig should b	ted			1 ☐ Yes 2 ☐ No 3	☐ Probably 4 🕦 Inknown
Vital Records,	- A to	Completed			autopsy	re autopsy findings available in to completion of cause of
= =	The law cate has page 2	Con			performed? dea 1 ☐ Yes 2X No 1 ☐	th? Yes 2□ No
Vita	ding Physician: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner? Hospital:	4.1	h (Check only one)	
of	Phys this ral dir	L.	Tightes 20190 To Inpatient 20 EH/Ot	The state of the s	me 5 Residence 6 Other 28d. Describe how injury occurred	(Specify)
on	th. : After funer	tion	1 Natural 5 Pending (Month, Day Year)	njury Work?	choked on food w	hile eating
Division	Attending r death. actor: Afte	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		28f. Location (Street and Number City or Town, State) Ann	
Ö	s afte	Cert	Annapolitan Ass	sisted Living	84 N. Old Mill E	Bottom Rd.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the time, date and place, d/or investigation, in my opinion, death occurr	and due to the cause(s) and mann red at the time, date and place, and	er as stated. I due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (/	Month, Day, Year)
	\bigcirc		- Francis is ma	Doo 631	4) 4/1	2/06
_	(5)		30. Name and address of person who completed cause of death (Item 23a) Arvind Desai, M.D. 115 Roesler B		•	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2006	A		
		· ·	MIN'TO COOL	-		

			1 - For State Registrar	State o	f Marylar			nt of H te of L		and Mo	ental Hy	gien Reg. N	. U U U	13643	
	St. Sp. May	es es	1. Decedent's Name (First, Middle, La	ast)							2. Date of De	aath Da	ay Year	3. Time of Death	
ı	Physici /Medic		James Edward Pe		April					006	7:20 A. M				
1	Examir		4a. Facility Name (If not institution, gi	ve street and nur	mber)		4b. Cit	, Town, or	Location o	of Death		40	c. County of Death		
ų.			3365 Southern Av		7.4. (/.				d, Ma				ince Geo		
	Funeral Director			Sex 1(X) M 2 □ F	7. Age (In yrs. 84	. last birthday) Yrs.	Month		Hours	Min.	8. Date of Bit (Month, Da	nn ay, Year	9. Birth	place (State or Foreign intry)	
1	a.		Usual Residence of Decedent								9/14/	1921	Virg	ınıa	
	yland		10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits	
	a-f-el	to	Maryland Prince	Georges	Sui	tland								1 X Yes 2 ☐ No	
	or 28	Director	10e. Street and Number				10f. 2	ip Code				10g. C	itizen of What Cou	intry?	
	23a	iai	3365 Southern Av					746					ted Stat		
	er de	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Dec If Yes, sp	edent of Hi ecity Cuba	spanic Orig n, Mexican	gin? (Spec 1, Puerto F	cify Yes or No Rican, etc.)	o-	 Race - Amer Black, White 		
9	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 🗍 Yes If Yes, Giv Year or D	/8		1 🗀 Yes	2 ∏ No	Specify:				Specify: Bla	ck	
3	2 hou	edt	15. Decedent's E	ducation	u103.	16a. Dece	dent's Us	ual Occupa	ation			16b. h	Cind of Business/I	ndustry	
<u>د</u>	n n	piet	(Specify only highest gi	ade completed) College (1	1 405 5 1	(Give	kind of v	rork done d use retired	luring most	t of workin	ng				
7	d with	Completed	10th	College (1	1-401 3+)	Lice	nsed	Prac	tical	Nurs	se	M	edical		
g	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "naturel", or iteme 23e or 28e-f ehow event, the Medical Exart ar must be notified at	Bec	17. Father's Name (First, Middle, Las	-							(First, Middle				
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. Is marked other than "naturel", or iteme 23e or 28e-f show aumatic event, the Medical Examinationals be notified at	2	Louis Adam receison									waru			
	permit. Pages 1 end 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic a <u>once</u> .		19a. Informant's Name/Relationship Elouise Peterso								Route Numb	Md .	p Code)		
	ages 1 e nt of He t: If Item r or othe		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 [Place of Dispo cometery, crei	matory o	other plan	Cem. 4		ate 2006		ocation - City or T		
	artme ortani Injury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	-		_			s of Facilit			2221	Homas		
g	Dep Cary		1 Little	1 0	MAIN	-				55	38 Mar	İbor	Homes o Pike	747	
			23a. Part . Enter the disease, or cor	nplications that o	aused the dea	ith. Do not ent	er the m	ode of dying	g, such as	cardiac or	restvi. respiratory a	rrest,	rid: 20	Approximate	
	Physician /Medical		23a. Part Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) CANCER OF PROSTATE												
			disease or condition resulting in death)	a	(or as a conse		PICE	15/14/	<u> </u>						
	Examiner		Sequentially list conditions												
	D 2	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quaries of):											
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٥ ×	eath certific attending p	/Me	IF FEMALE:	23c. If yes, out	come of pregn	ancy							204 5-1		
X Q Q	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live b	inth 2 ☐ Feta	al death 3	Ectopic Other (pregnancy					23d. Date of deliv Month	Day Year	
o.	at the de by the a	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	52	Jan Colon (spanny)										
J.	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	by Ph	Part II. Other significant conditions	contributing to de	leath but not resulting in the underlying cause given in Part I.						23e. Did 1	id tobacco use contribute to the cause of		the cause of death?	
ecords,	quire n sig	D D									1 🗆	Yes 2	No 3□Pro	bably 4 □Unknown	
ပ္သ	> 11 0	ojet					24a. Was			opsy findings available					
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VITA	sician: Th certificate rector, pag	BeC	25. Was case referred to medical						26. Place	of Death	(Check only		3	20.10	
<u>o</u>	d is	To	examiner? 1 ☐ Yes 2 ☑ No			ER/Outpatier	nt 3 🗆 🛭	Othe Othe	9r. 4 🗀 Nui	rsing Hom	ne 5 Resi	dence	6 ☐Other (Speci	fy)	
			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time o Injury	f	28c. Injury Work			8d. Describe				
<u>S</u>	uttendi death. ctor: A y the fu	cati	2 Accident investigation	ha			М		res 2□N						
Division	after di after di Direct din by i	Certification;	3 Suicide 6 Could not determined	28e. Place buildi	Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospitel or Attending 24 hours after death. Funeral Director: Afte tely filled in by the fune		non Continue of the state of	husta: = = = =											
	To the Hospitel of within 24 hours at The Funeral Decembletely filled in	Medical	29a. Certifier 1 TC Certifying P (Check only one) 2 Medical Exa	miner: On the bi	best of my kn asis of examina ner stated.	owledge, deat ation and/or in	n occurre vestigatio	d at the timen, in my op	e, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s date an	s) and manner as s d place, and due t	stated. to the cause(s)	
	To the	Mec	29b. Signature and title of certifier)					9c. License				29d. Da	ate signed (Month,	Day, Year)	
	(10)		cayanson	was ML)			DI	6619	î		AD	iil 6 .	2006	
	0		30. Name and a mess of person who	completed caus	e of death (Ita	m 23a) (Tvne	Print)					. 17	- 0,0		
	SP		C.VERGARA - SO	APES 9	1940 F	RANKLI	N S	GUA	RE D	12.	BATIA	IORL	iil 6,	21236	
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42. Country of Death 28. Anchor Way 29. Social Security Number 29. Social Security Number 20. Social Security Number 20. Social Security Number 21. Social Security Number 21. Social Security Number 22. Social Security Number 23. Social Security Number 24. Social Security Number 25. Social Security Number 26. Social Security Number 27. Social Security Number 28. Anchor Way 29. Social Security Number 29. Social Security Number 20. Social Security Number 20. Social Security Number 21. Social Security Number 22. Social Security Number 23. Social Security Number 24. Social Security Number 25. Social Security Number 26. Social Security Number 27. Social Security Number 28. Anchor Way 29. Social Security Number 100. City, Town or Location MD Worcester 100. Sites and Number 100. Specify Claim of What Country 100. Specify Claim of What Country 100. Specify Claim of What Country 101. Maria Status 102. Was Decedent Even in U.S. 103. Mass Decedent of Higgs on Conjpin (Specify Yes or No- 11. Yes ag MN or Specify 11. Maria Status 11. Maria Status 12. Was Decedent Even in U.S. 12. Was Decedent E	7:14 a. M		
Social Security Number 8. Sex 216-44-7845 1			
216-44-7845 June 21, 1929 Mary June 2			
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Ruth Ann Timmons (Daughter) 30812 Irons Lane Dagsboro, DE 19939 20a. Method of Disposition 1 2 3 4 4 2 3 4 3 4 3 4 4 4 3 4 3 4 4 4 4			
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29a. Certifier 1 Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated	lad .		
29a. Certifier 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) 29d. Date signed. (Month, Die 29d. Date s	he cause(s)		
	ay, Year)		
4/17/2	2006		
30. Name and address of person wife completed cause of death (Item 23a) (Type, Print)			
1346 S. D. VIS LOW ST. SALISBURY MD 21804 Rodrey	A. I MIN		
Stato 31. Date filed (Month, Pey, Year) 77, 0000 32. Registrar's Signature	A. Wenrich		

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 31 2006 4:00 P			1 - State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artmer rtificat	t of Head	alth a eath	and Mer		iene () (16	13645
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S. Social Security Number 5. See 10 ml 20 F 7. April (first as a principle) 10 ml		r	4a. Facility Name (If not institution, give	street and num	ber)		4b. City,			of Death		4c. County	of Death	
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MULLER MD DO0 58 290 4/4/06	pletely fill	edical	29a. Certifier	sician: To the b ner: On the bas and manne	est of my kno sis of examina or stated.	owledge, death ation and/or inv	occurred estigation	at the time, o	date and on, death	place, and h occurred a	due to the ca	use(s) and ma ite and place, a	nner as s and due to	tated. the cause(s)
	woo l			was		MD				290	29			Day, Year)

			For State Registrar	State of Mar		artment of He tificate of D			ene () () ()	13646
١	Physicia /Medic	ın	1. Decedent's Name (First, Middle, Last,	. Reed	A			2. Date of Death Month APRIL	Day Yes 10 2006	
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of D	
	**		PRINCE GEORGE'S		1-16:46 1	CHEVERL	Y If Under 24 Hrs.	0.5	PRINCE C	
	Funeral Director	9	377-08-3300	7. Age (1. Age	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, JUNE 10	Year) 9.1 1949 WA	Birthplace (State or Foreign Country) SHINGTON, DC
	with the Maryland a or 28a-f show		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f g	Director	MD PRINCE GE	ORGE'S	MITCHELL					1√2 Yes 2 □ No
	with th	Dire	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	Country?
	e 23g	eral	10207 FORESTGROV	E LANE 12. Was Decedent Eve	arin II S 13 1	20721	nanic Origin? (Sn	acty Ves or No-	U.S.A.	merican Indian,
326	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23a or 28a-f ehow int, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🕅 No	Specify:	Rican, etc.)	Specify:	
Ş	in 72 hours n "natural", ledical Ex	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupa kind of work done do	tion	ina	16b. Kind of Busine	ss/Industry
Maryland 21215-0036	within 7 lene. then "n	Completed	(Specify only highest grad	College (1-4or 5+) 1 YR	life. L	TING ROOM	_		PRIVATE	
Ö	be filed withital Hygiene. d other then	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, N	Maiden Sumame)	
lan I		To B	JOSEPH L. NICHOL	AS			EDITH	M. THO	RNHILL	
a Z	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Relationship (T)	rpe, Print)		ng Address (Street a			•	
	and 2 ealth n 27 i		DONNA PLOWDEN/DA	AUGHTER						RYLAND 20721
Baltimore,	-185		20a. Method of Disposition 1 ဩ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of Dispo cemetery, cren HARMONY	natory or other place	4/15		LANDOVER,	
Balt	permit. Pages Department of Important: If It eny Injury or once.		21. Signature of Funeral Service Licens	La U		2. Name and Address 474 LANDO	J,		KINS FUNE	
W.			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused th	e death. Do not ent					Approximate Interval Between
1	Physician _/Medical		Immediate Cause (Final disease or condition resulting in death)	- Pancra	eatits consequence of):					Onset and Death
i	Examiner		Sequentially list conditions, if any, leading to immediate	b						
	uted d ansit	Examiner	Cause (Disease or injury	Due to (or as a d	consequence of):					
60,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
68760	ficate physics the	edicai		d						
O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	☐Fetal death 3☐	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
J	ires that t signed by d be detac	þ	Part II. Other significant conditions co	ntributing to death but i	not resulting in the u	nderlying cause give	n in Part I.			to the cause of death? Probably 4 Munknown
Vital Records,	The law require	Completed						24a. Was ar autops perform	y prior	
ā			25. Was case referred to medical				26. Place of Deat	perform 1 Yes 2		es 2 No
=	Physician: rthis certifica ral director, p	To Be	eyaminer?	Hospital: 1 Miliopatient	2 ER/Outpatien	nt 3 DOA Othe	-		nce 6 ☐Other (S	inecuty)
on of	ding Phy h. After this funeral c		27. Manner of Death 1 KNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury Work		28d. Describe ho		poony
Division of	E # : 0	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)			28f. Location (Str City or Town		Rural Route Number,
	To the Hospital or Atterwithin 24 hours after de to to the Funeral Directo completely filled in by the	Medical C		sician: To the best of iner: On the basis of earth and manner state	xamination and/or in					
	within 2	Mec	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Mo	onth, Day, Year)
	(11)		Karen -	2 1800	967	0 4	13183	S	4/10/0	6
	de		30. Name and address of person who co	ompleted cause of dea		Print)	DR	CHEN	ERLY M	D 20185
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's				S. Free v	1	,,,,,
	Registr	ar	APR 1 4 2006 🔏	alue de	Condit.					

			For State Registrar	State of Maryland		irtment of H <i>tificate of L</i>			ne 006	13647
	Physici		Decedent's Name (First, Middle, Last) LEVORA	RIGGIN	S			2. Date of Death APRIL 1	Bay 2006	3. Time of Death 4:15 a M
	/Medic Examin		4a. Fecility Name (If not institution, give st.	reet and number)			Location of Death		4c. County of Death	TODGE 6
	Funeral	. =	7 3 0 5 LOCH RAVEN 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	TEMPLE If Under 1 Year Months Days	HILLS If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	PRINCE G	EORGES place (State or Foreign htry)
İ,	Director		1 68 - 28 - 0076 Usual Residence of Decedent	M 21XF 86	Yrs.	Months Days	Hours Mill.	12-15-1		BAMA
	iryland ihow	_	10a. State 10b. County	10c. City,	Town or Lo	cation		-		10d. Inside City Limits 11X Yes 2 ☐ No
	the Ma 28e-f	Director	MD P.G. 10e. Street and Number	TEM	PLE	HILLS 10f. Zip Code		100	. Citizen of What Cou	
	ath with 23¢ or	rai Di	7305 LOCH RAVEN				0748		U.S.A.	
980	72 hours after death with the Maryland natural', or Items 23g or 28e-f show Jigal Exanifer qualite natified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1	li li	Vas Decedent of Hi i Yes, specify Cuba □ Yes 🌠 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: BL	etc.
215-003	c * a	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done o OO NOT use retired	during most of work	ing 16	b. Kind of Business/In	dustry
7	filed w Hygien Sther th		12th 17. Father's Name (First, Middle, Last)		Н	OMEMAKE		e (First, Middle, Ma	N/A iden Sumame)	
Maryland	should be filed withlind Mental Hygiene. I marked other then umatic event, II e M	To Be	BISHOP	TOLIEN			MARY	JAN		
Mar	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type SHIRLEY BREELAND						City or Town, State, Zip PLE HILLS	
more,	pes 1 ar of Hea If item or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	ro.	ce of Dispo	sition (Name of natory or other plac	e)		c. Location - City or To	own, State
altim	permit. Pages Department of I Importent: If its any Injury or o		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Ligensee	HAR		MEMORIA Name and Addres		PROFESSION OF THE RESERVE OF THE RES	ANDOVER, OR FUNERA	MARYLAND
Ba	Dep Imp		1/5. E. Ja	wor.	1	0583 MI	DDLEPOR	r LANE,	WHITE PL	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	LEM		9*		AR DIS	Approximate Interval Between prest and Deat
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
68760,	icate be executed physician and s the burial-transit	edicai Exa	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
39 xo			IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnan					23d. Date of delive	ery
	at the death certi I by the attending stached for use a	Physician/M	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 0 9 \(\text{Unknown} \)	1 Live birth 2 Fetal of 4 Pregnant at time of dea		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
<u> </u>	quires that n signed b uld be deta	by	Part II. Other significant conditions cont	ributing to death but not resul	ting in the u	nderlying cause give	en in Part I.		cco use contribute to t	
Il Records,	or Attending Physicien: The law requires that the death certil ifter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a in by the funeral director,	Completed						24a. Was an autopsy performe 1 \(\text{Yes} \) 24	prior to co	ppsy findings available impletion of cause of $2 \square X_0$
Vital	yslcien: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3□ DOA Oth		h <i>(Check only one)</i> ome 5 X Residen	ce 6 □Other (Specia	ý)
n of	ding Phy h. After thi funeral	lon: T	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe how	injury occurred	
Division	a Hospital or Attending & 24 hours after death. 2 Funerel Director: After etely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)			Yes 2 □No	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospital or Atten within 24 hours after deat to the Funerel Director: completely filled in by the	edical C		cian: To the best of my know er: On the basis of examination and manner stated.						
)	To the within to the comp	Me	29b. Signature and title of certifier			29c. Licenso	1854	5 A1	Date signed (Month,	
	CIC		30. Name at address of person who con		23a) (Type,	6 23	CANK	R WA	LOVE, N	, 2006 1d. 20602
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		01100	C - 1 C			
	Regist	af	APR 1 4 2006	me so the						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 APRIL 14, **Physician** 2304 JERRY SERFASS RILEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth MAY 7, 1941 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 😿 F WASHINGTON, DC 64 Yrs. 579-56-4943 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits rel', or Itema 23a or 28a-f ehow Exempler must be notified at 1 XYes 2 □ No Director ACCOKEEK PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 20607 16012 MANNING ROAD WEST Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♥ No If Yes, Give A Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **MERCHANDISER** RETAIL permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEAH MATILDA MONEY SERFASS HARLEN VICTOR SERFASS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16012 MANNING ROAD W, ACCOKEEK, MD 20607 LEAH SMITH/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) THE HUNTT CREMATORY APRIL 18, 2006 WALDORF, MARYLAND 21. Sprinture of Funeral Servicens 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner BREAST CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ▼No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ACUTE TUBULAR NECRUSIS OF KIDNEYS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours e To the Funeral L (artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier 29b. Signature and title of certifier R Pinentel m.o. D0038147 BENJAMIN Z. PIMENTEL, M.D. 601 POST DEFUE RD #1A, WALDORE MD ZUGOZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 8 2006

		,	1 - For State Registrar	State of Mar	ryland / Dep <i>Ce</i>	artment	of Heal	th and M ath		ene 0 0	6 136	49
			Decedent's Name (First, Middle, Last)						2. Date of Death	1	3. Time of	Death
H	⊳ Physici Medic/		Carlinda		Redinge	r				16, 2006		a ^M
	Examin		4a. Facility Name (If not institution, give s					ation of Death		4c. County of		
			323 City View Terra 5. Social Security Number 6. Sep		(In yrs. last birthday		nberlan	Inder 24 Hrs.	8. Date of Birth	Allegar). Birthplace (State o	or Foreign
	Funeral Director			M 2 XF 6		Months	Days Ho	ours Min.	May 19	, 1942	MD	
	D >		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation					10d. Inside C	ity Limits
	Aaryla I show	ō	MD Allegan		_	berlan	d				1 ✓ Yes	
	28a-	Director	10e. Street and Number			10f. Zip	Code		10	g. Citizen of Wh	at Country?	
	h with	al Di	323 City View Terra	ace			21	502		USA	4	
	be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "naturel", or items 23a or 28a-f show event, the Medical Exeminar must be maillist at	Funeral	The state of the s	12. Was Decedent Ev Armed Forces?		Was Deced	ent of Hispan ify Cuban, Me	ic Origin? (Sp exican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.	
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No Sp	ecify:		Specify:	white	
21215-003	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usua	Occupation			16b. Kind of Busi		
215	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)) life.	DO NOT us	k done during e retired)	g most of work				
N	filed wi Hygien Sther th		17. Father's Name (First, Middle, Last)		Aide		10 1	Mother's Name	e (First, Middle, M	Nursing F		
anc	d be fi	o Be	Irvin Lowery						parks) Lo			
Maryland	s 1 and 2 should be f Health and Mental Item 27 is marked o other treumatic eve	2	19a. Informant's Name/Relationship (Ty				(Street and N	lumber or Run	al Route Number,	City or Town, St		
	1 and 2 Health a tem 27 is		Carla Townsend	daugh			/iew Te		Cumb		MD 2150)2
ore	Pages 1 nent of Hi int: if Iter iry or oth		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Disp cemetery, cre	matory or of	her place)	1	4/19/2006		ity or Town, State	1D
altimore,	permit. Pages Department of I Important: If It any Injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	90 4	Hillcrest Me			i		Cumber	iand iv	טוי
Ba	Department of the post of the		Minhalan	y Aca	100lls				ome, PA e: Cumberla	and MD 2	1502	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the	he death. Do not er	iter the mode	of dying, sui	ch as cardiac	or respiratory arre	est,	Approximation Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	Metasta	atic Col	on C	arcino	ma			Onset and	on His
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):							•
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ă	death certifi e attending i od for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		Or				23d. Date	of delivery	
œ.	0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		□Ectopic pre □ Other (spe				Month	n Day	Year
<u>Ч</u>	The law requires that the de ate has been signed by the a page 2 should be detached	Phy	9 Unknown Part II. Other significant conditions con		t not resulting in the	undorhina a	uso awan in	Parti	23e Did toh	acco use contrib	ute to the cause of	teath?
ds,	signed signed d be de	d by	Anemia	moduly to death but	thot resulting in the	underlying ca	1030 giveri iii	r divi.	1 □ Ye		Probably 4	
CO	w require been sign	iete	Chronic Kidney D.	icano					24a. Was a	n 24b. We	ere autopsy findings	available
Re	The lav te has age 2	Completed	Chronic Maney V.	Sea) C					autops perform	y pri ned? de	or to completion of d ath? ☐Yes 2.☐1√0	ause of
ita	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?					Place of Deat	h (Check only on			
<u>5</u>	Physic this co	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	lospital: 1 ☐ Inpatient 28a. Date of Injury				☐ Nursing Ho	ome 5 Reside	nce 6 Other		
u O	Attending Physician: It death. ector: After this certification by the funeral director.	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	M	Bc. Injury at Work? 1 ☐ Yes	2 No	Zod. Lascribe no	m injury occurred	,	
Division of Vital Records, P.O. Box	Atten	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At home, farm, s	treet, factory	, office		28f. Location (St. City or Town	reet and Number	or Rural Route Nun	nber,
	Hospitei or Attending Ph 24 hours efter death. Funers! Director: Atter th tely filled in by the funeral	Cert										
	To the Hospitel or Attent within 24 hours efter deall To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami one)	ner: On the basis of e and manner state	examination and/or i	nvestigation,	at the time, di in my opinion	ate and place, n, death occur	and due to the ear red at the time, da	lass(s) and mani ate and place, an	lar as stated. d due to the cause(s	s)
	To the within To the Somple	Me	29b. Signature and title of certifier	<u> </u>	•	29c	. License nur	mber	2	9d. Date signed (Month, Day, Year)	
)			Christowher -	Jamon.	i Miss		D00599	87		April 1	7, 2006	
	3		30. Name and address of person who co	1		, Print)			C			
	<i>y</i>		Christopher Vagno 31. Date filed (Month, Day, Year)	ni, M.D.;	902 Setor	Drive	e Suit	e 303;		ana, MD	21502	
	Sta Registi		MAY 0 1 2006	Jan -	M. Agas	El.						

			1 - For State Registrar	State of	Marylar		artment rtificate			and M		giene Reg. No	JUD	13650
Ι,	φ¢. Dhuaisi	\$ \$	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month			3. Time of Death
	Physici /Medic		Nettie Simm	ons							April	10		8:10 P M
y	Examir		4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of	of Death		40	. County of Deat	h
18.		d) 1	Harborside Hea 5. Social Security Number 6			Chase last birthday)	If Under	1 Vear	Bowi		O Data of Bio			George's
	Funeral Director		578–40–5475 Usual Residence of Decedent	1□M 2XIF	75		Months	Days	Hours	Min.	8. Date of Bir (Month, Da Dec • 5	y, Year,		hplace (State or Foreign buntry) th Carolina
	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Itema 23a or 28a-f ehow ent, Ite Medical Examinan must be motified at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	e Ma	cto	Maryland Prince	George's				Se	at P1	.easa	nt			1 XYes 2 □ No
	with th	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What Co	untry?
	eath v	erai	6503 Rollingr	idge Dr. 12. Was Decede	nt Suprin II	c 12	Man Daned		20743					States
'	fter d	by Funerai	1 Never Married 2 Married	Armed Force	es?	.5.	If Yes, spec	ify Cubar	n, Mexican	, Puerto	cify Yes or No Rican, etc.)	•	14. Race - Ame Black, White	e, etc.
8	el', o		3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Date	_		1 ☐ Yes 2	₹No	Specify:				Specify:	frican nerican
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lan	id be ental ked o	To Be	David Ba										Rogers	
ary	shou ind M mar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura			or Town, State, 2	Zip Code)
Ž	and 2 alth a 27 is		William R. Bar:	row/Brothe	er	431	2 Delm	nar A	Ave.,	Tem	ple Hil	lls,	MD 207	748
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examinar must be indiffed at once.		20a. Method of Disposition 1 1 2 □ Cremation 3	□ Bomoval from Str		Place of Dispo	sition (Nam	e of her place)	D	ate	20c. L	ocation - City or	Town, State
Ĕ	Pag ment ant: I		4 Donation 5 Other (Spe			rmony 1	Memori	ial I	Park	4/18	/2006		Landover	, MD
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	Physician		23a. Part1. Inter the disease, or co shock or heart failure. List on Immediate Cause (Final disease or condition			ry Fai		a or dying	, such as	cardiac o	r respiratory ai	rest,		Approximate Interval Between Onset and Death 1 Day
4.	/Medical Examiner		resulting in death)		as a conseq									- 24)
张		4	Sequentially list conditions,		g Canc									3 Years
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 (5)	as a conseq	dence or).								
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9	ng ph as th	Medi	IF FEMALE:											
Box	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	gnancy					23d. Date of deli	•
0	the a	sici	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnan 9□Unknow		eath 5□	Other (spe	ecity)					Month	Day Year
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gp.	uires Isign Id be	d by		-		•					1 🗆 ነ			obably 4 Unknown
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<u>></u>	ding Physician: The lav h. After this certificate has funeral director, page 2	Tof	examiner? 1 ☐ Yes 2 █ X No	Hospital: 1 🗌 Inp	atient 2	ER/Outpatien	t 3 🗆 DO	A Other	r: 4 □XNur	rsing Hom	ne 5 🗆 Resid	lence	6 ∐Other (Spec	city)
E C	ing P	 0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury		Bc. Injury Work			8d. Describe h	ow inju	ry occurred	
S	death death tor: / the f	icat	2 Accident investigat 3 Suicide 6 Could not	be 200 Bloom of	Inium. At h		M		es 2 🗆 N		004 111 //			
Division of Vital Records,	after Direct	Certification:	4 ☐ Homicide determine	28e. Place of building,	etc. (Specif	y)	eet, factory,	office		2	18f. Location (S City or Tow	n, State	a) a)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	edical C	29a. Certifier (Clock only one) 1 Certifying I	Physician: To the be arrimer. On the basis and manner	s or examina	wledge, death	occurred a	it the time	e, date and	d place, a h occurre	nd due to the o	ause(s)) and manner as d place, and due	stated. to the cause(s)
	within 2 To the complete	Med	29b. Signature and title of certifier	0 1/1	1		29c.	License	number			29d. Da	te signed (Month	, Day, Year)
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	Examir	ier	4a. Facility Name (If not institution, given						Location of	of Death		ļ	c. County			
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b	Funeral Director			1□M 2 X □F	51	Yrs.	Months	Days	Hours	Min.	8. Date of Bi	95 ⁴)	Texa	place (State or htry) 15	, or orgin
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	within 72 hours after deeth with the Maryland ene. than "natural", or items 23a or 28a-f ehow tha Madical Examinat must be quilified at	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U	J.S. 13.	Was Dec	edent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race	- Americ	an Indian,	
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lan	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ehow eny injury or other treumatic event, the Madical Examinar must be multised at 200ce.		19a. Informant's Name/Relationship	Type, Print)							d Route Numb	er, City	or Town,	State, Zip	Code)	
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בסר	if its		20a. Method of Disposition 1 Burial 2 Cremation 3			Place of Dispo cemetery, crei						20c. L	ocation -	City or 10	own, State	
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	To the	Mec	29b. Signature and Ale of certifier	and manner	Stated.		25	c. License	number			29d. Da	ate signed	(Month,	Dey, Year)	
1	119		> Kular	race				Dy	72	50	7		-10			
	Una		30. Name and address of person who	completed cause of	of death (Iter	n 23a) (Type,	Print)	- (, ,			, t			- 0	
	del.	j	Litshree Nayak,					d Cl	never.	ly, l	MD 2078	35				
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4s. Facility Name (if not institution, give streat and number) 3.5515 Orchard Terrace Road 3.5515 Orchard Terrace Road 3.5504 Security Number 6 Security of Deamh 3.5504 Security Number 6 Security of Deamh 3.5504 Security Number 6 Security of Deamh 3.5504 Security Number 6 Security Orchard Terrace Road 3.5504 Security Number 6 Security Orchard Terrace Road 3.5504 Security Number 6 Security Orchard Terrace Road 3.5504 Security Number 6 Security Orchard Terrace Road 3.5504 Security Number 6 Security Orchard Terrace Road 3.5504 Security Number 6 Security Orchard Terrace Road 3.5504 Security Number 6 Security Orchard Terrace Road 3.5504 Security Number 6 Security Orchard Terrace Road 3.5504 Security Number 7 Security Number 7 Security Number 7 Security Number 8 Security Number 8 Security Number 8 Security Number 9 Secur		1- For State of Maryland Registrar	I / Department of Health and I Certificate of Death	Mental Hygien	.000 10000
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29a. Certifier (check only one) 29a. Certifier (check only one) 29a. Certifier (check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	ital or Atta)	,	City or Town, Sta	te)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/18/06 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) PAUL R FLEURY 31505 OR Chard Turace Westover MD 21871 State 31. Date filed (Month, Day, Year) ADD 2 0 2005	n 24 hou ne Funer	29a. Certifier (Check only one) (Check one) (Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Chec	on and/or investigation, in my opinion, death occu	rred at the time, date ar	nd place, and due to the cause(s)
State State	withii To the comp	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
30. Name and address of rison who completed cause of death (Item 23a) (Type, Print) PAUL R FLEURY 31505 OR Chard Tennace Westoven MD 21871 State 31. Date filed (Month, Day, Year) ADD 2.0. 2005		Paul & Flerey MD	DZ4872	4	118/06
State 31. Date filed (Month, Day, Year) 32. Regist It's Signature		30. Name and address of rison who completed cause of death (Item 2)	23a) (Type, Print) OR Chard TUN	ace We	stover MD 21871
		31. Date filed (Month, Day, Year) 32. Registy tr's Signatu	ire		

Please Type or Print in Black Indelible Ink

Marcel M. Swann State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of D Physician/ Month Day April 11, 2006 1653 hrs Medical Examiner Marcel Monroe Swann 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death N/B Rt. 301 @ Chew Rd Upper Marlboro Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Funeral Country) Days Months Hours Director 212-17-1599 1 X M 2 F 33 03/22/1973 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No items 23a or 28a-f show MD Upper Marlboro it Pages 1 and 2 should be filed within 72 hours after death with the Maryland rtment of Health and Memial Hygiene. refant: If item 27 is marked other than "natural", or items 23a or 28a-f sho y or other traumatic event, the Medical Examiner must be notified at once Prince George Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9115 Marlboro Pike, Lot 65 20772 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 **y** Married Yes Divorced If Yes, Give Year Specify: Black 3 Widowed 1 Yes 2 X No specify: þ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Complet most of working life. DO NOT use retired) Baltimore, MD 21215-0036 12 Truck Driver Covernment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Elizabeth Swann Robinson Thomas Wendell Harley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9115 Marlboro Pike, Lot 65, Upper Marlboro, MD 20772 Mulaika Swann/ Spouse 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 04/15/2006 Pomfret, MD St. Joseph's Church Cem 4 Donation 5 Other Specify 22. Name and Address of Facility Thornton Funeral Home, P.A. 21. Signature of Euneral Service Licensee Thornton Johnson Johnson Lydia C. 3439 Livingston Rd., Indian Head, MD 20640 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician en Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and yely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 1 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other; Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day Yeer) Apr 11, 2006 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27, Manner of Death Certification: Driver auto auto collision 1645 hrs Natural Yes 2 V No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 _ Could not be Suicide or Town, State) N/B Rt. 301 Chew Road, Upper Mariboro, MD determined within 24 hours a (Specify) Major Road / Highway Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 12, 2006 O.C.M.E. Josephay, MI 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela Southall, MD 31. Date filed (Month APRY 1 State Registrar

DHMH 17 Rev 1/2001 OCME 10/2003

		ı.	1 - For S	tate of Marylan		artment of H			iene 0 0 6	13655
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
45.	Physicia /Medic		ROBERT W. STASZN	Y				April 5	5, 2006 Year	5 PM
	Examin		4a. Facility Name (If not institution, give street	nt and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
1.00			Crescent Cities Nu			River				George's
\$.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
ļ.	Director		579-16-0851 Usual Residence of Decedent	90				March 22	. 1916	Hungary
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-fsh	tor	Maryland Prince Geo:	rge's Bi	centwoo	od				1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	ath w		4507 37th Street			2072	=		U.S.A.	
	er de	Funeral	, martar status	Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		merican Indian, hite, etc.
36	rs aft	by F	ar .	l 2XYes 2 □ No fYes, Give WW] Year or Dates:	II .	1☐Yes 2☒No	Specify:		Specify:	White
Ş	within 72 hours after death with the Maryland ene. then "natural", or items 23c or 28a-f show the Modical Exerciting to rectified.	ted	15. Decedent's Education	on	16a. Deced	dent's Usual Occupa	ation	1	16b. Kind of Busine	
215	hin 7: 9. "n Madi	ple	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4or 5+)	(Give life. L	kind of work done o DO NOT use retired	during most of world)	king	Cons	truction
2	ad wit	Completed	, , , , , , , , , , , , , , , , , , , ,	2	Bri	Lck Mason			Ricci	& Tanaglia
p	be filed v tal Hygie d other l event, 🗓	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	faiden Sumame)	
<u>X</u>	should be and Mental s marked o	2	Robert J. Staszny					na Sedila		
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type,	·		ng Address (Street a				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23s or 28a-f show any injury or other traumatic event. If a Modical Extention of the retifical angles.		Albert G. Staszny 20a. Method of Disposition	20b. P	lace of Dispo	37th Sta	1		Maryland Oc. Location - City	
ğ	Pages nent of ant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	vai from State	· .	natory or other plac	1			
Ħ	nit. Partme orten Injury	1	21. Signature of Fuperal Service Licensee	rie	_	tan Cremato . Name and Addres	ss of Facility Ga	09/2000 sch's Fu	neral Ho	ia, Virginia
Ba	Depariming permi		Villa A	-1701377						, MD 20781
	*		23a Part1. Enter the disease, or complication shock, or heart failure. List only one can		. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate
	Physician		tmmediate Cause (Final disease or condition	Due to (or as a consequ	501	erotic	Cand	of G.Sail	1, -	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):				10) Harl	9201.9
ы	Examiner		Sequentially list conditions, b. —							
	ed , sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
•	xecut and	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					
8760,	cate be executed obysician and the burial-transit	dical E								
9	tificate ng phy as the	ledic								
Вох	eath certific attending p for use as	M/u	230. Was decedent pregnant	f yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy			23d. Date of	
	ne deat the attr	sicia	1 Ves 2 No	4 Pregnant at time of de		Other (specify)			Month	Day Year
P.0	that the death cer ed by the attendir detached for use	Physician/Med	9 Unknown		ter a se			00- 014-1		e to the cause of death?
ŝ	se og eg	by	Part II. Other significant conditions contributions	Iting to death but not rest	inting in the ur	nderlying cause give	en in Part I.			Probably 4 Junknown
Record	w requir been si should	Completed	(202 (JR. Di						<u> </u>
360	has by ge 2 s	dm	Coronary au		eg to			24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of 1?
		e Co	Chwmz Ob/th 25. Was case referred to medical	carce r	UNS	disea		1 ☐ Yes 2	21No 1□Y	es 2□No
Vita	ysician: The la is certificate has director, page 2	0	examiner? 1 Yes 2 No Hosp	ital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe		th (Check only one	nce 6 🗆 Other (S	inacifu)
o	g Phys er this eral dir	n: To	27. Manner of Death 2	8a. Date of Injury (Month, Day Year)	28b. Time of		at at	28d. Describe how		pecity
0	trending Phosesthat cor: After the	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day Year)	mjary		Yes 2 □ No			
Division of	after de Directo	Certification:	3 Suicide 6 Could not be determined 2	 Place of Injury - At he building, etc. (Specify) 	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	Hospital or A 4 hours after Funeral Directely filled in by								oa sanasana	
	Hospital	edical	(Check only 2 Medical Examiner:	in: To the best of my known the basis of examination and manner stated.	wledge, death tion and/or inv	noccurred at the time vestigation, in my or	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To the Hospital or Atlanding Physician: within 24 hours after ceath. To the Funeral Direc or: After this certifics completely filled in by he funeral director, i	Mec	29b. Signature and title of certifier	7 /		29c. License	number	29	d. Date signed (Mo	onth, Day, Year)
	r s r ö		A alex	eloula	ul.	110	1852	- A	m220	2006
0	E		30 Name and address of person who compl	eted cause of death (Item	23a) (Type,	Print)		A 4	/ 11	111 - 20
	0		PAI A DEVI	DE MISI	1203	() see	NSGON	1 tal Hy	14/501/	e MD 20181
	Sta		31. Date filed (Month, Day, Year) APR 1 1 2006	2. Registrar's Signa	ture	<i>P</i> .		· ·		
	Registr	aı	W. V. T. T. 5000	A CHIEF A	KARE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 2:44PM 2006 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll County Carroll Westminster
If Under 1 Year | If Under 24 Hrs. ospita 5. Social Security Number 6. Sex 8. Date of Birth (Month Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 95 Days Hours Min 204-03-6567 1**⊈** M 2□ F MaryTand **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked othar than "natural", or Itams 23s or 28e-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Itams 23c or 28e-f show MD 1 Yes 2 No Director Carroll County Taneytown 10e. Street and Number 2404 Trevanion Road 10f. Zip Code 10g. Citizen of What Country? 21787 USA Funeral 7 Is marked other than "natural", or Itams traumatic evant, the Medical Execution reprint 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 → Widowed 4 □ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Marshall Ruth Shulley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is any injury or other traignts. P. O. Box 440 Taneytown, Maryland 21787 Harry Shulley, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Fairfield Union Cem. 4-25-06 Fairfield, Pa. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jeffrey L. Davis F.H. 23a. PA11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12525 Bradbury Ave. Smithsburg, Maryland Immediate Cause (Final disease or condition resulting in death) Physician inermorequiator /Medical Examiner response Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed rinary Tract Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes marasmus bone disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy Benighn 2 No Delerium 25. Was case referred to medical examiner? 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Diractor: After this c 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manyer of Death 1 Natural 28a. Date of Injury (Month, Day 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Bostor

MAY 0 1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arroll

32. Agistrar's Signatur

Hospita

29c. License number

D28462

enter

Westminster

29d. Date signed (Month, Day, Year)

2006

		1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F		-	giene Reg. No. 006	13657
Phys	ician	Decedent's Name (First, Middle, Decedent's Name (First, Middle)		i+			2. Date of De	Day Year	
/Me	dical	Dorothy 4a. Facility Name (If not institution,			4b City Town o	or Location of Death	April	14, 200 C	
Exar	niner	SALISBURY REHAB				Y, MD. 21		WICOMIC	
Funer	al,	5. Social Security Number 6		Age (In yrs. last birthday			8. Date of Birt (Month, Da		rthplace (State or Foreign country)
Directo	or	577-26-5069 Usual Residence of Decedent	I	90 Yrs.			8/22/		shington,DC
/land		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
the Marylar 28a-f show	ţ	Maryland Wicon	nico	Salisbu	cy				Maria Yes 2 No
or 28	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
ier death w Itams 23a	rai	1514 Riverside	2 Drive	ant Evenie II S 12	2180		nadi. Vas ar Na	USA 14. Race - Am	nion ladias
5-0036 72 hours after death with the Maryland reatural; or Itama 23a or 28a-f show digal Examinant an invalue at	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie	Armed Force	X No	Was Decedent of H		Rican, etc.)	Black, Wh	
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2121 Within iene.	d Ho	Elementary/Secondary (0-12)	College (1-4	or 5+)	ookkeeper	٥,		Insurance	_
ind 2 be filed at Hygin ed other	Se C	17. Father's Name (First, Middle, La	ast)					Maiden Surname)	
aryland should be marked over umait over	은	Oscar Metz				Isabel		ivener	
Mary Id 2 shou Ith and M 27 is mar		19a. fnformant's Name/Relationshi Rosalie D. Suit/						er, City or Town, State, , Salisbury ,	
O a a a a a		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Location - City o	
\(\mathcal{E}\) \(\mathcal{E}		1 ☐ Burial 2 【ACremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate	ematory or other place y Cremato	1	7/06	Salisbur	v, MD
Baltimor permit. Pages Department of I Important: If its	once.	21. Signature of Funeral Service Li	cen ree				ome Prof	fessional A	
M 82EE	ä	Keell 10	Meriney		OUT Show F	dill Rd.,	Salisbu	ury, MD 218	304
	940	23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cau	ised the death. Do not er th line.	iter the mode of	, uch as cardiac	or respiratory ai	rrest,	Approximate Interval Between Onset and Death
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687 tiflicate ig phys	edic		a						
Box 6 auth certific	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		□Ectopic pregnancy	,		23d. Date of de	
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ecord law requir as been s 2 should	Completed						24a. Was		utopsy findings available
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Divisic If or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of	Injury - At home, farm, si , etc. (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Number or R	dural Route Number,
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DIVI To the Hospital or At within 24 hours after or to the Funeral Direct completely filled in by	edical	29a. Certifier 1 Gertifying (Check only 2 Medical E:	Chyelcian: To the basi kaminer: On the basi and manner	est of my knowledge, dea is of examination and/or in ristated	th occurred at the time nvestigation, in my o	ne, date and place, pinion, death occur	red at the time,	date and place, and du	s stated. e to the cause(s)
To the within To the complex	Me	29b. Signature and title of certifier	-/)		29c. License	e number		29d. Date signed (Mon	th, Day, Year)
	1	I MAN	1/4		0	2934	09	0 4/	4/20
3	3	30. Name and address of person wi				7	1	/	100
0		WILLIAM ROBINS, 31. Date filed (Month, Day, Year)		CIVIC AVE.,	SALISBUR	Y, MD. 2	1804		
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			1 - For State Registrar	State of Ma	ryland /		artment of tificate o			, ,	iene	006	13658
	Physici	an	Decedent's Name (First, Middle, Last) Verna May	Simon						2. Date of Dear		Year 2006 +	3. Time of Death
ì	/Medic Examin		4a. Facility Name (If not institution, give si	treet and number)		f	4b. City, Town	or Location	n of Death	April	4c. C	ounty of Death	•
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036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other then "natural", or itame 23a or 28a-f ehow aumatic event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 🖾 Widowed 4 Divorced	2. Was Decedent Et Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Vas Decedent of Yes, specify C			pecify Yes or No- Rican, etc.)		. Race - Ameri Black, White, pecify: Wh	
Maryland 21215-0036	d within 72 ho piene. r then "natur the Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+		(Give life. l	lent's Usual Occ kind of work don DO NOT use reti	ne durina ma	ost of work	king		of Business/Ir	,
and	B E D	To Be C	17. Father's Name (First, Middle, Last) Fred R. Weller							e (First, Middle, I			
Mary	s 1 and 2 should I f Health and Men item 27 ie marke other traumatic	Ĕ	19a. Informant's Name/Relationship (Type John Simon Jr/son	e, Print)	1			et and Num	ber or Rur	ral Route Number Salisbury	•		o Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra		20a. Method of Disposition 1	emoval from State	20b. Place For Ceme	of Dispo	sition (Name of natory or other p				20c. Loca	ation - City or T	
Balti	permit. Departri Importa eny inju		21. Igna Tre Funeral Service Lidense	Pour	_	22	Name and Add HOLTOWA 501 Sno	ress of Fac y Fune w Hil	eral Rd.	Home Pro	fess	ional A	Association 804
	Physician		3a. Part 1. Enter the disease, or complications, or heart failure. List only one immediate Cause (Final disease or condition	ations that a sed each line	Э.			ying, such a	s cardiac	or respiratory arri			Approximate Interval Between Onset and Death 5 Houkl
	/Medical Examiner		resulting in death)	Due to (or as a	consequence GNP	ce of): ANT	Hy	PER	TER	N 0120			1 DAY
,0	be executed sicien and burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	LTE	N21	JE H	EAR	7]	2 A 3 2 1 C	`€		204EARS
P.O. Box 68760	ath certificate itending physor use as the	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic, If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal dea		Ectopic pregnar	ncy			23	d. Date of deliv	ery Day Year
	equires that the de en signed by the a ould be detached f	Ď	Part II. Other significant conditions cont	ributing to death but			LLITY		t I. 		oacco use os 2 🗆		he cause of death? pably 4 Onknown
Division of Vital Records,		Completed			-					24a. Was a autops perform	v	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
֡֝֝֝֝֟֝֝֝֝֝֡֟֝֝֡֟֝֝֡֡֟֝	nysiciar nis certif I directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ospital: 1 Inpatien	t 2□ER/	Outpatien	t 3 DOA	\.		th <i>Check only on</i> ome 5 ☐ Reside		☐Other (Speci	(y)
onoi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		27. Manner of D ath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28t	D. Time of Injury	l v	juryat /ork? □Yes 2[□No	28d. Describe ho	w injury o	occurred	
DIXIS	s after de si Directo ed in by ti	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, (Specify)	, farm, str	eet, factory, offic	0		28f. Location (St City or Town		Number or Run	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) Certifying Physical Examin	ician: To the best of er: On the basis of e and manner state	examination	ige, death and/or inv	occurred at the restigation, in m	time, date a y opinion, de	and place, eath occur	and due to the cared at the time, d	ause(s) ar ate and p	nd manner as s lace, and due t	stated. o the cause(s)
)	Withii comp		29b. Signature and title of certifier	or -	3	7,	29c. Lice	nse number	69	62	9d. Date :	signed (Month,	Day, Year)
	Par		29b. Signature and title of certifier 30. Name and address of person who cor M. S. F. J. R. A. Z. J.	mpleted cause of dea	ath (Item 23)	a) (Type, SUL	Print) RE	GION	AL 1	MEDICA	12	ENTE	2.MD 21081
X-	Sta Registr	te	31. Date filed (Month, Day, Year) ADD 1 Q 20	32. Registrar			1 4						

06-02735 Stacey Sartori

Please Type or Print in Black Indelible Ink

tacey Saiton		State of Maryland / Department of Health and Mental Hyglene 1- For State Registrar Certificate of Death Reg. No. 2006	3659
Physician Medical Examine	1	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Pay Year	
		4a. Facility Name ((if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Marys Hospital 4c. County of Death Leonardtown 5t. Mary's	
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Str.	ate or
Director		216-06-9098 1 M 2 F 37 Yrs. Months Days Hours Min. 1-23-69 Foreign Country) //	20
any	L.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	e City Limits
Varyland 28a-f show any d at once.	<u>.</u>	DE SUSSEX MILLS BORD 106. Street and Number 107. Zip Code 109. Citizen of What Country?	s 2 No
ith the Maryland 23a or 28a-f she notified at once		24299 - CANAL DRIVE 19966 1)5A	
or items 23		11. Marital Status 1	Black,
after des	. J	3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify: Specify: WHIT.	E
"natur		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry	
yo36	najaidilloo	12 MEDICAL ASST. WANTICOKE HO	SPITAL
21215-0036 Uld be filed within 7 Mental Hygiene marked other thau c event, the Medica		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DIANE FUZARETA MENOTT	-
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other transmitie event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	, ,
re, M 1 and 2 Health fitem 2	-	DIANE E. HAYES — MOTHER 29705—MILLS BORD HIGHWAY MILLS BARD DE 1994 20a. Method of Disposition (Name of cemetery, Date) 20b. Place of Disposition (Name of cemetery, Date) 20c. Location - City or Town, State crematory or other place)	e e
Baltimore, permit Pages I a Department of He important: If ite injury or other to		4 Donation 5 Other Specify: WOODLAWN CEMETERY 4 28 06 MIUSBORD D	E
Balt permit Depart Impor injury	}	21. Signature of Funeral Service Ligensee 22. Name and Address of Facility BENNIE SmITH F/H 21.9-WASHINGTON ST. MILLSBORD DE 19966	
Physician /Medical		23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Methadone and Pripoxyphene intoxication complicated by Betwee	nate Interval n Onset and
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted Insit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
executed an and al - transi		d.	
'60, sate be obysicine buri		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 687 death certific he attending i		23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (Specify) Month Day	Year
that the death certificate by the attending detached for use as the control of th	rnysician/	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of th	of death?
P.C		1 Yes 2 ✓ No 3 Probably 4	
Division of Vital Records, lat or Attending Physician: The law requing a staffer death at Director. After this certificate has been signed in by the funeral director, page 2 should different a Doctor and a staffer of the Doctor and a staffer of the different and a staffer of the	Completed by	24a Was an 24b. Were autopsy finding autopsy performed? death?	
in of Vital Reco		1 ✓ Yes 2 No 1 ✓ Yes 2 25. Was case referred to medical 26 Place of Death (Check only one)	No
n of Vital Jing Physician: After this certif funeral director,		examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other	
on of nding P tth		27. Manner of Death 28a. Date of Injury (Month. Day, Year) 1 Natural 5 Pending RNd 4/22/2006 Fnd 12:24 PM 1 Yes 2X No unk 28b. Time of Injury 28c. Injury at Work? 1 Yes 2X No unk	
ivisic or Atte after des Directo I in by th	Certification	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route No. 27 Taylor Could not be	lumber, City
Division Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the		29a Certifier 1 Certifier Physician To the best of my legal/legal death accurred at the time data and along and due to the gray (c) and	, ,
Division To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the state of the state	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	2	29b. Signature and the of ceriffier 29c. License number 29d Date signed (Month, Day, Ye O.C. M.E. April 23, 2006	ear)
	-	30. Name and address of person who completed cause of death (Item 23a)	
Stat	10	Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year). 32. Registrar's Signature	
Registra	ar		

should be filed within 72 hours after death with the Maryland Mannal Hygene. And Mannal Hygene. Instruct of other than "natural", or items 23a or 28a-f show a higher than "natural", or items 23a or 28a-f show a higher than "natural", or items 23a or 28a-f show a higher than "natural", or items 23a or 28a-f show a higher than "natural", or items 23a or 28a-f show a higher than "natural" and "natural". To Be Completed by Funeral Director	4a. Facility Name (if no Princ	J. not institution, give s George's nber 6. Sex 939 necedent 10b. County d Prince nd Avenu 1 2 Married Divorced 5. Decedent's Educ only highest grade lary (0-12)	Thomas Street and number) S Hospital 7. Age (In) 8 10c. Georges 12. Was Decedent Ever in Armed Forces? 12. Was Decedent Ever in Armed Forces? 12. Yes, Give Year or Dates:	Yrs. iast birthday, 4 Yrs. City, Town or Li Temp n U.S. 13. WII	Chever Months December 19 10f. Zip Co	Als	s. 8. Date of Birth (Month, Day, 02/26)	Day Year 14, 2006 4c. County of Dea Prince Year) 9. Bir CX 1922 Ne	5:59 And Georges thplece (State or Foreign ountry) W York 10d. Inside City Limit 1 Yes 2000 ountry?
be fled within 72 hours after death with the Maryland that Hygiens and Hydre than "naturel; or items 23a or 28a-f show advent, tra Medical Francher must be notified at Second Examination of the Completed by Funeral Director	168-18-2 Usuat Residence of D 10a. State Maryland 10e. Street and Numb 4107 221 11. Marital Status 1 Never Married 3 Widowed 4 (Specify Elementary/Second 12 17. Father's Name (Final Joseph 19a. Informant's Name	939 Pecedent Pob. County d Prince nd Avenu 1 2 Married Divorced 5. Decedent's Educe only highest grade lary (0-12) irst, Middle, Last)	De Georges 10c. De Georges 12. Was Decedent Ever in Armed Forces? TYN Yes, Give Year or Dates: Cation is completed)	4 Yrs. City, Town or L. Temp n U.S. 13. WII	Months D ocation 1e Hil 10f. Zip Co 20748 Was Decedent If Yes, specify 1 Yes 2 28	. 1s .de .tof Hispanic Origin? (Cuban, Mexican, Pue	(Month, Day, 02/26)	Og. Citizen of What Course USA 14. Race - American Black, White	10d. Inside City Limit 1 Yes 2000 ountry?
be filed within 72 stal Hygiene. Ind other than "nai event, ins Madic Be Complete	Maryland 10e. Street and Numb 4107 221 11. Marital Status 1 Never Married 3 Widowed 4 (Specify Elementary/Second 12 17. Father's Name (Fi	Prince and Avenu a 2 Married Divorced 5. Decedent's Educe only highest grade lary (0-12) irst, Middle, Last)	De Georges 12. Was Decedent Ever i Armed Forces? TYM Yes. Give year or Dates: cation a completed)	Temp	le Hil 10f. Zip Co 20748 Was Decedent's 1 Yes 2 28	de } t of Hispanic Origin? (Cuban, Mexican, Pue		USA 14. Race - Ame Black, Whit	1 ☐ Yes 2₹∑No ountry?
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	Joseph 19a. Informant's Name 19a. Informant's Name	lary (0-12)		life.		ccupation	orkina	Specify: Wh	
	Joseph 19a. Informant's Name 19a. Informant's Name			Acc	DO NOT use n	lone during most of we etired)	J. Mary	Accounti	ing
3 2 5 5 1 F	19a. Informant's Nam						ame (First, Middle, A	Maiden Sumame)	
E E E			oe, Print) Nas - Wife		_	reet and Number or F	Rural Route Number,	City or Town, State, .	
Pages 1 and 2 nent of Health a nt: if item 27 is iry or other trai			emoval from State	 b. Place of Disposementary, cre 	osition (Name of matory or other		9/2006	20c. Location - City or	Town, State
permit. Pages Department of Important: If it eny injury or o	21. Signature of Fune			2	2 Name and A	ddress of Facility		Cheltenha Home, F on Hill,	
Physician	23a. Part1. Enter the shock, or heart! Immediate Cause (Fi disease or condition resulting in death)	failure. List only on nal	cations that caused the decause on each line. Bacterem	eath. Do not en	iter the mode of				Approximate Interval Between Onset and Death 4 Days
/Medical Examiner	Sequentially list cond	- (Due to (or as a condition of the conditi	sequence of): Bowel		se with	peritoni	.tis	2 Days
ate be executed hysicien and he burial-transit		C	Congesti		rt Fai	lure			5 weeks
in the law requires that the death certifical cate has been signed by the attending phy page 2 should be detached for use as the Completed by Physician/Medi		onths?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	⊒Ectopic pregn ⊒ Other (specif			23d. Date of de Month	livery Day Year
s been signed be strain should be deta	Part II. Other signification		tributing to death but not y Disease	resulting in the u	underlying caus	e given in Part I.		accoluse contribute to	
the law re ate has bee page 2 sho	Respir	atory F	ailure				24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings availat completion of cause o
hysician this certifii al director.	25. Was case referred examiner?	. н	ospital: 1 Mnpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatier 28b. Time o			Home 5 Reside	nce 6 Other (Spe	cify)
ital or Attending F rs after death. al Director: After ed in by the funera Certification:	XXX Natural 2	5 Pending investigation 6 Could not be determined	28e. Place of Injury - A building, etc. (Spi	t home, farm, str	М	1 ☐ Yes 2 ☐ No	28f. Location (Str. City or Town	eet and Number or Ro	ural Route Number,
Hospital or 14 hours atte Funeral Dir tely filled in I		XCertifying Phys Medical Examin	ician: To the best of my er: On the basis of exam	knowledge, deat	th occurred at the	ne time, date and place	e, and due to the ca	use(s) and manner as	s stated.
To the Hosp within 24 hou To the Fune completely fil	29b. Signature and it)	and manner stated.		29c. Lie	cense number		Od. Date signed (Mont	h, Day, Year)
(8)			mpteted cause of death (I			Rd., Che	everly,	MD 20785	

ORIGINAL

	ľ	For State Registrar	State of Marylar		partment of H ertificate of I			iene () ()	6	3661
Physical at		1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Year	3. Time of Death
Physici /Medio			on, Jr.				April_			12:10 a [™]
Examir	ier	4a. Facility Name (If not institution, give st		n 1	,	Location of Death		4c. County		400
		Prince George Comm 5. Social Security Number 6. Sex	7. Age (In yrs.		Chever1	-	8. Date of Birth		e Geor	e (State or Foreign
Funeral Director			^{M 2□ F} 5	2 Yrs.	Months Days	Hours Min.	Dec. 16	, 1953	Country	ngton, DC
D _		Usual Residence of Decedent	10- 6:	. Taua	1					fnside City Limits
aryiar	۲	10a. State 10b. County		ty, Town or					100.	1 XYes 2 □ No
the M	Director	Maryland Prince Ge	oge Ca	pitol	Heights 101. Zip Code		10	Og. Citizen of V	Vhat Country	17
with	ā	7232 Joplin Street			2074	.3		USA		
death ms 23	Funeral	<u> </u>	2. Was Decedent Ever in L	J.S. 1	3. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race	e - American	
f and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Heath and Mental Hygiene. The marked other than "natural", or items 23s or 28s-f show ther traumatic event, the Medical Evant, and missing the notified at	by	1 Never Married 2 🗷 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	Hican, etc.)	Specify	k, White, etc : B1a	
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Gi	cedent's Usuaf Occup	durina most of work	ing	16b. Kind of Bu	ısıness/İndus	stry
vithin ne hen	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		. DO NOT use retired vice Techn			Distric	+ C	
iled v Hygie ther t		17. Father's Name (First, Middle, Last)		Ser	vice recili	18. Mother's Nam				ernment
d be f	o Be	James L. Thornton,	Sr.			Marcia	Michaux			
Shoull nd Me mark	ဥ	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Ma	ailing Address (Street	and Number or Run	al Route Number,	City or Town,	State, Zip Co	ode)
alth a 2 27 is		Marcia Michaux / M	other	723	2 Joplin S	treet, Ca	pitol He	ights.	IID 2	0743
of Herm		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dis	sposition (Name of rematory or other place		Date	20c. Location -	City or Town	n, State
Pages nent of I ant: If It ury or o		4 □ Donation 5 □ Other (Specify)	Fo	rt Li	ncoln Ceme	tery 4/13	3/2006 1	Brentwo	od, Ma	ryland
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event. Item Magnes.		21. Signature of Funeral Service License	V. Mell	1	Fort Linco	ss of Facility In Funera ensburg Ro	al Home bad, Bre	ntwood.	MD 2	20722
් ර ආ		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the dea						A	pproximate iterval Between
Physician	-	tmmediate Cause (Finaf disease or condition	Mvocardia1	Infar	ction				0	nset and Death
/Medical		resulting in death)	Due to (or as a conse							
Examiner		Sequentially list conditions, b.	Coronary A	tery	Disease					
ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence or):						
cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):						<u> </u>
siciar siciar buri	dicai E	L _d							all the second	
ifficating phy as the	ledic									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in t.y the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. ff yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death	3 □Ectopic pregnancy 5 □ Other (specify) _	/	ur_	23d. Dat Mo	te of delivery inth Da	
that the		Part If. Other significant conditions con	tributing to death but not re	sulting in the	e underlying cause giv	ren in Part I.	23e. Did tol	pacco use cont	ribute to the	cause of death?
requires een sigr	ed by	Hypertension					1 □ Y€	s 2 No	3 Probab	ly 4 ⊠Unknown
aw res	Completed						24a. Was a autops	n 24b. \	Were autopsy	y findings available detion of cause of
The la	mo						perforr	ned?	death? 1 ☐ Yes 2[
ian: ortifica ctor, p	BeC	25. Was case referred to medical examiner?					th (Check only on	e)		
hysio	2	1 ☐ Yes 2 💽 No		ER/Outpa		4 Ituising in	ome 5 Reside			
ng en		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injui	y Wo	ry at rk? Yes 2 □ No	28d. Describe ho	ow injury occur	red	
s after de	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, ify)	street, factory, office		28f. Location (SI City or Town		er or Rural F	Route Number,
To the Hospital or Attending Within 24 hours after death. To the Funeral Director: After completely filled in ty the fune	edicai (ician: To the best of my knier: On the basis of examinand manner stated.							
To the comp	M	29b. Signature and title of certifier			29c. Licens		2	9d. Date signe	d (Month, Da	y, Year)
2		(Chros Duy			12:	300 DC			4/7/00	
e by		30. Name and add as of person who co				NOTTO 1 N	4D 2078	5	, ,	
78		Alfreda Burris, M. 31. Dete filed (Month, Day, Year)	22. Registrar's Sigr		DITAE, CL	reverry, r	Д 4010.			
St Regist	ate trar		Been A		Ri					
OHMH 17 Rev 1/		APR 1 1 2006	Marie A	14						-

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Mary		artment of H rtificate of L			Reg. No UU	13662
Physi /Med		Decedent's Name (First, Middle, La FRANCES CHRISTI	NE TURNER				2. Date of De Month April	22 2006	5 1430 M
Exam	iner	4a. Facility Name (If not institution, gir Upper Chesapeake	Medical Cent		4b. City, Town, or Be1			4c. County of D	ord
Funera Directo	_		Sex 7. Age (Ir 1 M 2X) F 49	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		y, Year)	Birthplace (State or Foreign Country) Cyland
Maryland -f show	tor	10a. State 10b. County PA York	10	c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ▼No
n with the	Funeral Director	10e. Street and Number 79 Baxter Road			10f. Zip Code 173	14		10g. Citizen of What USA	Country?
1215-0036 within 72 hours after death with the Maryland one. then "natural; or items 23s or 28s-1 show na Medical Example or 18s-1 show na Medical Example or 18s-1	þ	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - A Black, W Specify: B	
	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupa kind of work done of DO NOT use retired tenance Te	<i>furi</i> ng most of wo !)		16b. Kind of Busine	
Iryiand 2 should be filed and Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Las Buddy Johnson	υ	<u> </u>				Maiden Sumame) etta Gordon	ı
, Maryland and 2 should be file bith and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship Roman S. Turner,			ng Address <i>(Street a</i> axter Roa			er, City or Town, Stat '314	a, Zip Coda)
Baltimore, Maryla permit. Pages 1 and 2 should Department of Heelit and Men Important: if Item 27 is marke any injury or other traumatic.		20a. Method of Disposition 1 ABurial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	20b. Place of Dispo cometery, cre Trinity	osition (Name of matory or other plac AME Cemete	ery 4/27	/2006	Delta, Pa	
Balt permit. Departi Import		21. Signature of Funeral Service Lie	· Lovel	edes		eral Hom		Delta, Pa	A 17314
bhysicial be executed /Medica Examine physicial and burial-transit site burial-transit	Icai Examiner	23a/Part1. Extende disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, is ading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	macrani onsequence of): DIC onsequence of): Sections	al hen	norrhage			Interval Between Onset and Death
O. Box 6 the death certifi y the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death 3 (□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
tha tha	b	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	underlying cause give	en in Part I.			e to the cause of death? Probably 4 Donknown
The The ate h	Completed						24a. Was autor perfo 1 Yes	an 24b. Were prior death 2 No 1 1	
of Vital Physician: T this certificate ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatie	nt 3□ DOA Oth	00	ath (Check only o	one) dence 6 Other (5	ipecify)
ding h. After	1⊢	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. Injun			how injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division to the control ospitel or attentions after deat uneral Director: sly filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	building, etc. (5	Specify)			City or To	wn, State)	Rural Route Number,
the H hin 24 the F nplete	Medical	(Check only 2 Medical Ext	miner: On the basis of ex and manner stated	amination and/or in		pinion, death occ			due to the cause(s)
To With		29b. Signature and title of certifier	el .			06342	0		22,2006
10			Siddig	500 Uppe	Print) er Chesape	eake Dri	ve, Bel	Air, MD 2	21014
Regi	State strar	31. Date filed (Month, Pay, Year)	32. Regištrar's		Jales				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 4/13/2006 Month Day 1. Decedent's Name (First, Middle, Last) **Physician** Bernard Moran Tennyson 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner REGIONOR MEDICAL CONTA HICOMICO FON INSUCO 3AU364 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F 164-18-1199 83 Director 3/12/1923 Maryland Usual Residence of Decedent e filed within 72 hours after death with the Maryland it Hygiene.
other then "naturel", or Iteme 23a or 28a-f show vent, the Medical Examinat must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Wicomico Salisbury 1X Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 S. Schumaker Dr., Apt. 8 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Armed Forces (
1 Ares 2 No Marines 1 Yes 2 No Year or Dates: WW II 1 Never Married 2 Married þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0·12) College (1-4or 5+) Accountant State Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked otheny any fujury or other traumatic event sons. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernard Tennyson Mamie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Tennyson/wife 1103 S. Schumaker Dr., Apt. 8, Salisbury, MD 21804 20b. Place of Disposition (Name of cometery, crematory prother place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/06 4 ☐ Donation 5 ☐ Other (Specify) Lutherville, MD 21. Signature of Funeral Service Licensee 22 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PNEU MONIA ASPIRATION 2 days /Medical Due to (or as a consequence of): Examiner ASCY1) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1☐ Yes 2 No 1 Tes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ပ္ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury s efter de... 5 Pending М 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) while DO57359 DR. USHA April 14/5 2006 NATESAN 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 57, S. DIVISION SALISBURY 1415 4021804 31. Date filed (Month Ray, Year) 2006 3 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

O. Box 68760

Vital Records,

Division of

Gernard

		Please I	State of Ma	ryland / Dep	artment of H	lealth and l		_	Die.	10001.
	-	State Registrar		Ce	rtificate of	Death		g. No.	Ü	10004
Physicia		Decedent's Name (First, Middle, Last, Shirley Mae	rodd				2. Date of Deat Month April		Year 006	3. Time of Death 7:50 a M
/Medica		4a. Facility Name (If not institution, give		·	4b. City. Town, o	r Location of Deat		4c. County		
Examine	r	2107 Hudson Roa	_ '''			oridge				ester
Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs. Hours Min.		Year)	9. Birthp	place (State or Foreign
Director		213-22-7859 Usual Residence of Decedent	M 2625F	77 Yrs.	Months Days	PROUIS IVIII.	June 9,			yland
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show Impatic event, it is Modical Experient must be notified at	to	10a. State 10b. County 10ches	ter	10c. City, Town or L		mbridge			1	10d. Inside City Limits 1 ☐ Yes 2 MNo
with the be notified	Funeral Director	10e. Street and Number 2107 Hudson Road			10f. Zip Code	21613	1	0g. Citizen of V USA	Vhat Cour	ntry?
eath (era	11. Marital Status	12. Was Decedent E	ver in U.S. 13	. Was Decedent of H If Yes, specify Cub		ipecify Yes or No-		e - Americ	can Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Modical Examines must be notified at once.	by Fun	1 Never Married 2 Married 3 ★Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🗖 No	an, Mexican, Puerl Specify:	to Rican, etc.)	Specify	k, White, : wh	_{etc.} ite
"natura	Completed	15. Decedent's Edu (Specify only highest grad	cation	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of wo		16b. Kind of B	usiness/In	dustry
withir than	d L	Elementary/Secondary (0-12)	College (1-4or 5-	-)	owner	-,		uphols	terv	shop
Hygin Hygin ant, I am	ပ္	17. Father's Name (First, Middle, Last)			OWIGE	18. Mother's Nar	me (First, Middle, M			
ked of	To Be	Edward Elzey				Helen	Phillips			
shou and M a mar umat	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mai	ling Address (Street	and Number or Ru	ural Route Number	City or Town,	State, Zip	Code)
and 2 alth a 127 is or tra		Holly Elzey	daughter	210	07 Hudson	Road, Ca			613	
Titen Toth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of Disp cemetery, cri	osition (Name of ematory or other pla	сө)	Date	20c. Location -	City or To	own, State
Pag Pag ment ant: h		'4 □Donayon 5 □Other (Specify)		Dorchest	er Memoria		-	Cambri		
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	99	Í	22. Name and Addre		Thomas Fu Lambridge		ome 1613	
1.0	Ì	23a. Part Enter the disease, or comp show, or heart failure. List only o	ications that caused ne cause on each line	the death. Do not e	nter the mode of dyin	ng, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	a cerel	provascul	ar accid	lent				5 minutes
/Medical Examiner		resulting in death)		consequence of):						
THE REAL PROPERTY.	Ļ	Sequentially list conditions,	b. — Due to (or as a	consequence of):						
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ificate g phy: as the	edic		v						-	
box ath cert attending for use a	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		□Ectopic pregnanc	.,			te of delive	
b death	hyslcian/Medl	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at t		Other (specify)			Мо	nth	Day Year
d by t	Phy	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying cause on	ven in Part I	23e. Did tob	acco use cont	ribute to t	he cause of death?
The law requires that the death certificate the has been signed by the attending physogge 2 should be detached for use as the	ed by PI	Part II. Other significant conditions to	minuting to dealined		andonying daddo gr					pably 4 Unknown
aw re as be	ompleted						24a. Was a autops	٧	Were auto	ppsy findings available impletion of cause of
The The ate his page	E						perform		death? I 🔲 Yes	2 No
VICIAN: T	BeC	25. Was case referred to medical examiner?					ath (Check only on			
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ion of Vital med ading Physician: The lav Ith: After this certificate has s funeral director, page 2		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	Year) 28b. Time Injury	Wo		28d. Describe ho	w injury occur	red	
INISION I or Attending after death. Director: Afte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, s . <i>(Specify)</i>	street, factory, office		28f. Location (St City or Town		er or Rura	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical C		rsician: To the best of iner: On the basis of and manner sta	examination and/or						
thin 2 the or the	Med	29b. Signature and title of certifier) // Sta	7	29c. Licens	se number	2	9d. Date signe	d (Month,	Day, Year)
F 3 F 8			1XV		70	50804		4-17	-00	
		30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type	e, Print)					ζ
	10	Mark Malkus	M.D.	408 Byrn	Street	Cambrid	Je, MD	21613		
Stat Registra		31. Date filed (Month, Aap Rear) 8	ompleted cause of de M.D. 200632. Registra	rs Signature	Sports		,			

	•		1 - For State Registrar	State of	Marylan		artmen			and M	ental Hyg	jiene	2000	13665
	Physici		1. Decedent's Name (First, Middle, La Florence		nite	Va	n Em	on			2. Date of Dea Month April 2		^y 2006 ^{Year}	3. Time of Death 4:25am M
	/Medic Examin		4a. Facility Name (If not institution, given Kline Hospice H		nber)		Mc	ount	Location o				. County of Deat Frederi	
	Funeral Director		216-46-85/2	ex □M 2Å F	7. Age (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year Days	ff Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day August	11,	9. Birt 1919 Ma	hplace (State or Foreign buntry) aryland
	Maryland I-f ahow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic	ck	10c. Cit	y, Town or Lo		eder	ick					10d. Inside City Limits 1 ☐ Yes 21 No
	or 28g	Director	10e. Street and Number				10f. Zip					10g. Ci	tizen of What Co	ountry?
	s 23s		5955 Quin Orcha	T	dent Ever in U	C 12	Was Doon	217		ain? (Spe	cify Ves or No-		U.S.A.	rican Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: If Itam 27 is marked other than "naturel", or items 23a or 28a-f ahow eny injury or other traumatic event, the Madical Exartment must be invitted at anone.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒️Widowed 4 □ Divorced	Armed For 1 Tyes If Yes, Giv Year or Da	rces? 2 (XNo e		ff Yes, spec		Specify:	n, Puerto F	cify Yes or No- Rican, etc.)		Black, Whit	
Maryland 21215-0036	vithin 72 ho ne. han "natur nedical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1	-4or 5+)	1	dent's Usua kind of wo DO NOT us eache	ork done d se retired	during most ()	t of workir	ng		and of Business	
and 5	d be filed v ental Hygie ked other t c event, th	To Be Co	12 17. Father's Name (First, Middle, Last Benjamin White,						18. Mothe		(First, Middle, rter Gr	Maider	Sumame)	•
ary	2 shoul and M le mari aumati		19a. Informant's Name/Relationship (Type, Print)			-						or Town, State, 2	
e, S	1 and Heelth am 27 ther tr		Mason W. Gray IV 20a. Method of Disposition		20b. F	Place of Dispo	sition (Nar	me of	-		e, Mary ^{ate}		d 21773	
altimore,	Pages ent of nt: If it ry or o		1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr		state	semetery, crei ithsbu				Apri 20	1 25, 06		•	, Maryland
Balti	epartm porta ny inju		21. Signature of Funeral Service Lice	nsee	,				ss of Facility	•	J.L. L	avi	s Funer	al Home
ш	20539	_	23a. Part1. Enter the disease, or com	Davis									g, Mary.	Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on e	ach fine. ateral	Pneumo		Je or dyln	g, such as	cardiac o	respiratory an	esi,		Interval Between Onset and Death Weeks
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8760, <	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec									
P.O. Box 68	ne death certifi the attending I hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		inth 2∏Feta antattime of o	al death 3	Ectopic p						23d. Date of del Month	ivery Day Year
rds, P.	quires thet the signed by and be detacted	þ	Part II. Other significant conditions Polymyolgia R			sufting in the u	nderlying o	cause giv	en in Part I.					o the cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should	Completed									24a. Was autop perfor 1 Yes		24b. Were au prior to death?	utopsy findings available completion of cause of
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital				0.5			(Check only or	ne)		Hospice
on of \	ding Physicien: The lav h. After this certificate has funeral director, page 2	tion: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending Output Investigated Investigated	28a. Date (Mon	npatient 2 c of Injury th, Day Year)	28b. Time of Injury		28c. Injur Wor		2	ne 5 Resid		6 ∰Other (Spe iry occurred	House
Divisi	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determined	28e. Place	of Injury - At h ng, etc. (Speci						28f. Location (S City or Tow	îtreet ai n, Stat	nd Number or Ri e)	ural Route Number,
	he Hospital n 24 hours a he Funerel I pletely filled	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the b										
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29	150	e number	5,1			ate signed (Mont	
)	. \		30. Name and address of person who	completed caus					126				April 25	, 2006
	7		Allen J. Gibson	MD	1475 1	Taney A	ve. I	Frede	erick,	, Mar	yland 2	2170	2-5127	
, 5	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 1 200	6 32. R	egistrar's Sign	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 5 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** C. Von Hagel Virginia 0920 04 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner -astor 160 Easton Memorial 6. Sex at If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 12/19/1908 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 X F 97 Virgińia 215-50-7864 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County iteme 23a or 28e-f ehow the Medical Examiner must be notified at X Yes 2 No Director Talbot Maryland Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA 244 Brookwood Ave. deeth y Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If Item 27 is marked other then "netural", or item any injury or other traumatic event, it a Medical source. 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Specify: white þ 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 11 Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hercelia Gore Herbert B. Corley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 46, Easton, MD 21601 Margaret Mayo/daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Columbia Gardens 1 Durial 2 Cremation 3 Removal from State 4/17/06 * 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Va Cemetery 21. Signature of Funeral Service Ucahsee land Addres of Facility | House Professional Association Approximate Interval Between Onset and Death 23a. Part1. Enter the dismisse, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) disease renal -stage End Physician ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 4 Uhknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Tyes 2 200 Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Maturat M 1 ☐ Yes 2 ☐ No death. 2 Accident hours after deat 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours a To the Funeral C Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier rangthan DOS APRIL13, 2006

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

State Registrar

Vaidyanathan 219 S. Washington St., Easton, MD 21601 Dr. Lakshmi 32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1 - For State Registrar	State of Maryland		artment of H tificate of I			ene g. No.	13667
4		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
Physic		Eunice Le	e Wilson					7, 2006	12:00P M
/Med Exam		4a. Facility Name (If not institution, give st	reet and number)	-	4b. City, Town, or	Location of Death		4c. County of Deat	h
_na		123 Sultan Avenue			Capito	1 Height	S	Prince G	eorge
Funera	1	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
Directo		236-48-5287	м 2⊠ г 70	Yrs.	Working Buy 9	110010	May 6,	1935 West	. Virginia
D _		Usual Residence of Decedent	10c City	Town or Lo					10d. Inside City Limits
irylar show	_	10a. State 10b. County							1 K Yes 2 □ No
Ba-f.	5	Maryland Prince Ge	eorge Cap	itol	Heights				
ith th		10e. Street and Number			10f. Zip Code	0.74.2	10	og. Citizen of What Co United S	
ath w	Funeral Director	123 Sultan Avenue				20743			
r de	Tue	Tr. Marital States	Was Decedent Ever in U.S Armed Forces?	13.	Mas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
s afte		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1□Yes 2No	Specify:		Specify: B	lack
hours	b by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	16a Daga	dent's Usual Occup	ation		16b. Kind of Business/	Industry
72 u	Completed	15. Decedent's Educ (Specify only highest grade		(Give	kind of work done	durina most of work	ing	TOD. TAILE OF BESTIESS	maastry
Mithir Mithig	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)		keeping N			Privat	e
Hygie nt.		17. Father's Name (First, Middle, Last)		110000			e (First, Middle, N	Maiden Sumame)	
ntal l	Be	Danks Carter				Annie	King		
d Me	၉	19a. Informant's Name/Relationship (Typ	ne Print)	19b Mailir	ng Address (Street	and Number or Rui	rai Route Number.	City or Town, State, 2	Zip Code)
h an 7 is r	1					NW: Wash		DC. 20010	
Healt Healt ther		Sonya M. Wilson/Dau	ignter 20b. Pla		Sition (Name of matory or other place			20c. Location - City or	Town, State
2 = 1 = 2 = 2		1 Burial 2 □ Cremation 3 □ Re	amoval from State				2/2006 1		v.m.
mit. Pages partment of portant: If it		4 Donation 5 Other (Specify)			emorial E Name and Addre		Fore Fu	Landover, I neral Home	S S
paritimities, interpretable filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel" or items 23a or 28a-f show any injury or other traumatic event, the Madical Experiment mast be notified at		21. Signature of Funeral Service License	1000		Name and Addre	ss of Facility	5538 Ma	rlboro Pik	e
4024	-	23a. Part1. Enter the disease, ir complice shock, or hear the ure. List only on	MUX	Kananani	or the mode of during	a cuch as cardiac		ille, MD.	20747 Approximate
hysicial be executed by training and by training the british and british training the british training the british training train	al	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Probable Due to (or as a consequ Atherosc Due to (or as a consequ Due to (or as a consequ	ence of): Leroti ence of):					
death certified of for use a	Physician/MedI	IF FEMALE: 23b. Was decedent pregnant in the past 12 meths?	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnanc	у	-	23d. Date of de Month	livery Day Year
ords, r.C requires that the een signed by th hould be detache	by P	Part II. Other significant conditions con	tributing to death but not resu	tting in the u	nderlying cause gr	ven in Part I.		pacco use contribute to	
w requires the been signatured be							1 □ Y€	s 2 No 3 P	robably 4 XUnknown
eco law re law re law re 2 sho	Completed						24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
The lar	Ē						autops perform	ned? death? 2⊠No 1 ☐ Yes	2 No
- C) L	0	25. Was case referred to medical			7//	26. Place of Dea	th (Check only on		
	To B	examiner?	ospital: 1 Inpatient 2 E	ER/Outpatie	nt 3 DOA Ott			ence 6 Other (Spe	ecify)
_ = _			28a. Date of Injury	28b. Time o				w injury occurred	
on adding th.	1	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
UNISION Hospital or Attending 24 hours after death. Funeral Diractor: After etely filled in by the fune	Certification.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st)	reet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
To the Hospital or within 24 hours aft. To the Funeral Discompletely filled in	Olealo		sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, dear ion and/or in	th occurred at the travestigation, in my	me, date and place	, and due to the corred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
To the vithin 2 complet	M	29b. Signature and title of certifier			29c. Licen:	se number		9d. Date signed (Mon	•
(10))	bech h.			DC16	016		April 10,	2006
(,)		30. Name and address of person who co	impleted cause of death (Item	23а) (Туре	, Print)				
27	7	Eugene Miknowski 1				, DC.			
234	State	31. Date filed (Month, Day, Year) APR 1 3 2006	32. Registrar's Signal	ture					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yeer WATIS 2006 /Medical 4a. Facility Name (If not institution, give street and number).
PLEASANT VIEW NURSING HOME 4b. City, Town, or Location of Death
PLO OLD NATIONAL PIKE MOUNT ALY 4c. County of Death Examiner MOUNT AIRY
If Under 1 Year If Under 24 Hrs. 8. Da CARROL Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 ☐ M 2 ☑ F Yrs. Director 235-58-2456 67 12/12/1938 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10h County 10a State 10d. Inside City Limits rel', or items 23s or 28a-f show Examiner items to rediffed at Completed by Funeral Director 1 ☐ Yes 2 No Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4101 Baltimore National Pike 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. ant: It item 27 is marked other then "naturel; or Item It item 27 is marked other then "naturel; or Item Item Alfor Eps. item Iny or other theumatic event, Item Alfor Eps. item Iny 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Jubilee Foods Deli 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Randall Smith 2 Effie Griffeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place)

Date

13.05 Toggenburg Dr. Finksburg, MD 21048

Date 20c. Location - City or Town, State Briton Weber (cousin) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) S. Carroll Crematory 4/13/2006 Winfield, MI-Burrier-Queen Funeral Home and Crematory, P.A. 222. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator waters. Field, MD 21.33 shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician META STATIC BREASTS CARCINOMA Montey /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expets.) Due to (or as a consequence of) by Physician/Medical Examiner burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Dependant Diabeta 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed ulmonory obstructive 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ost coarts ritis Degenastive 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 5 Pending investigation 1 Matural after death.

I Diractor: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours af To the Funaral D completely filled i filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. B D. 30469 APRIL - 13, 2006 WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. B. VELLANKI 8850, CULUNBIA, 100 Parkway \$ 308. 7 Columbia, MD. 21045.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

APR 1 7 2006

Eleva & Spark

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day ELLA BOLAND WHITE March 28, 2006 8:35 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Washington Adventist Hospital Montgomery 7. Åge (In yrs. last birthday, If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Months Hours Director 78 424-30-6622 Oct. 2, 1927 Alabama Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or itams 23a or 28a-f shov The Medical Examinar must be notified at Director 1 X Yes 2 □ No Prince George's Maryland Mount Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3125 Queens Chapel Road, #101 20712 Funeral U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify: 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is markad othe any injury or other traumatic avent, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be 2 Frank Boland <u>Ethel Oaks</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn W. Colliere - Daughter 4005 Madison Street, Hyattsville, Maryland 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🏻 Burial 2 🔎 Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 4/1/2006 Brentwood, Maryland 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on yach line. Immediate Cause (Final disease of condition Physician Réspiratory Failure resulting in death) /Medical Due to (or as a consequence of) Examiner Aspiration Pneumonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Morbid Obesity: Clostridium Difficile Colitis: 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Renal Insufficiency; Congestive Heart Failure; 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No раде Osteoarthritis 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. onel within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45471 April 2, 2006 30. Name and address of perso who co pleted cause of death (Item 23a) (Type, Print) Yeheyis Negussie, MD Washington Adventist Hospital, Takoma Park, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 1 2006 Registrar

06-02652 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Tyreak Wilcher 1- For State Certificate of Death Rea No Registrar 2. Date of Death Decedent's Name (First, Middle.Last) Physician/ 2345 hrs April 18, 2006 Medical Examiner Tyreak V. Wilcher 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical System Baltimore Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Min. Director Country) October 10,1981 1 X M 24 Yrs PA 2 188-62-3054 Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10a. State 10b. County any 1 X Yes 2 No 28a-f show 23a or 28a-f shor Œci1 Elkton MD with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 12 Loran Court U.S.A. 14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S 13 Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Armed Forces? Married Yes 1 Black If Yes, Give Year 1 Yes 2 No specify: Specify 4 Divorced 3 Widowed the Medical Examiner ≥ or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Baltimore, MD 21215-0036 should be filed within and Mental Hygiene Maintenance Education 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessica B. Sheppard John H. Wilcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sho nent of Health and ant: If item 27 is Stacy Sheppard/Sister 705 Elk River Manor, North East, MD 21901 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Burial 2 Cremation 3 Removal from State permit. Pages
Department of
Important: 1 April 27,2006 North East, MD North East Cemetery Other Specify 9 22. Name and Address of Facility uperal Service License Andrew G. Gee Funeral Home Enter the disease, or complications that caused the death. Do not enter the moue of the place as called or tespitatory and shock, or heart Approximate Interva **Physician** Between Onset and e. List only one cause on each line /Medical Death a Stab wounds(2) of torso Immediate Cause (Final disease ⁵xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause Due to (or as a consequence of) events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical g physician a the burial -UNPENDED AMENDED item#28b, 28f, perME, g860, 10/6/06 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year Live birth 2 past 12 months' Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. à 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? this certificate has performed? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Fo the Hospital or Attending Physician: Division of Vital Be Other₄ examiner? Hospital: 1 / Inpatient 2 DOA Nursing Home 5 Residence 6 Other ER/Outpatient 3 Certification: To 1 V Yes 28a. Date of Injury (Month, Day,Year) FOUND: After 1 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death FOUND 2053pm Subject was stabbed Natural Yes 2 V No Pending Apr 18, 2006 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) **161 N. Main St. Extension** Costa Hiller Costa North East, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire Could not be Suicide (Specify) Local street 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2006

State Registrar

30 Name and address of person who completed cause of death (Item 23a)
Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
31. Date filed (Mark Coynea) 2006 32 Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy Elizabeth Wagner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 907 Kentucky Avenue Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 3, 1924 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Days Hours Director 219-14-5350 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. cither then "natural", or items 23a or 28a-f ehov vent, the Medical Exercis at must be notitled at Allegany MD Cumberland Funeral Director 1 ☐Xes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Kentucky Avenue 21502 USA Pages 1 and 2 should be fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No à Specify Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary **Doctor's Offices** 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Filtern 27 is marked of rother traumatic ever Hugh David McCov Maza Gertrude (Miller) McCov ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Wagner 907 Kentucky Avenue husband Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: if Ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Sunset Memorial Park 4/26/2006 Cumberland 4 ☐ Donation 5 ☐ Other (Specify) MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONVIan /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as ettending I 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Day Year 5 Other (specify) been signed by the should be detached P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t lirector, page 2 s 24a. Was an autopsy of Vital 1□ Yes 2 No director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only Hospital: Other: 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phys within 24 hours after death.
To the Funerei Director: Atter this completely filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 Natural 1 □Yes 2 □No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramaditya Poonai M.D. 924 Seton Drive Cumberland MD 21502 State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death April **Physician** 2006 8:40AM Annette Yarbrough /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Prince Georges 6516 Suitland Road Suitland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Dec. II, 1950 | Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 □ M 2 X F 229-74-8497 55 Yrs. Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Prince Georges Suitland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20746 6516 Suitland Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Hattie Childs Haywood Rayfield 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Earl Yarbrough/ Husband 6516 Suitland Rd.Suitland, MD 20746 20b. Plece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State Danville Memorial Gardens Burial 2 Cremetion 3 Removal from Stete 4/15/06 Danville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Greene Funeral Home, INC. 21. Signeture of Funeral Service Licensee Wan & Green 814 Franklin St.-Alexandria, VA22314 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Myocardial interction Unknown Examiner Physician/Medical Examiner physician end s the buriel-trensit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): sete hes been signed by the opage 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours etter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) 4.12.06 Rat- Fahr 043446 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 9801 Georgia Are Suit 3-41 Silver spring MD 20902 ROINTAN FARAHIFAL MO

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)

APR 1 3 2006

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item#1- State Registrar 3 per phy.,bg,4/20/06 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 04 OUNG 2006 WEY 10:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOMERS DUE Domerse 7 If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace Country) (State or Foreign **Funeral** Days 214-34-8514 12 M 2□ F Yrs. 04-01 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at field MD 151 1 Kes 2 No Director meisel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US.A 21817 COMERS Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Heme. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) aborer oultra 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any jury or other traumatic event sones. 18. Mother's Name (First, Middle, Maiden Sumame) Be oung 19a. Informant's Name/Rela onship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Marion, luppin 6450 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) ′ഘ enetela 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Funcial Home 4. Whong E. Ward Funcial Home 30639 Hampden Ame. Princess Ange ND 21853 2020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of): Box 68760 by Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□ Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 1 🗌 Yes 4 Unknown as been sig Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate a twom 12 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1. Pes 2 No 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

State Registrar

To the

31. Date liled (Month, Day, Year) APR 2 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MICHAEL

TKINS MO 32. Registrar's Signature

29c. License numbe

29d. Date signed (Month, Day, Year)

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			1 - For State Registrar	Claic of Marylan		tificate o		ind wo		2006	13674
	. 45	П	Decedent's Name (First, Middle, Last)						Date of Death		3. Time of Death
	Physici /Medic		Agnes Marie Yesh	nik					Month pril	10 2006	
	Examin		4a. Facility Name (If not institution, give s	treet and number)			n, or Location of			4c. County of De	
	<u> </u>		1030 Oak Drive	7 Ann //n //n	last birthdaul	If Under 1 Ye	estminst		Data of Bigh	Carr	
Ģ	Funeral Director		5. Social Security Number 6. Sex 196-22-8410	M 2DE	77 Yrs.	Months Da		Min.	Date of Birth (Month, Day,) (a rch 6	'ear) 9. 81	rthplace (State or Foreign Country) PA
	ס		Usual Residence of Decedent					1.1	alcii u	1929	FA
	anylan show	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Mi	ecto	MD Ca	rroll	Westn	inster			110	Cities of Miles C	
	with I	i Dir	1030 Oak Drive				L158		100	p. Citizen of What C USA	ountry ?
	me 2%	nera		12. Was Decedent Ever in U	.S. 13.		of Hispanic Orig Cuban, Mexican,	in? (Specify	Yes or No-	14. Race - Am	
9	or ite	by Funeral Director	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		t Yes, specmy 0 1 ☐ Yes 2 ☐ 5		, Puerto Rica	in, etc.)	Black, Wh	
8	be filed within 72 hours after death with the Maryland tal Hygiene. d other then *natural; or iteme 23s or 28s-f show event, the Madical Exeminar must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:							
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212	y with	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema				Own Ho	me
פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (Fi	rst, Middle, Ma	iden Sumame)	
ylaı	Menta Menta arked	Tof	Robert Nelson				Har	riet :	Burkhar	dt	
Maryland 21215-0036	l 2 sho and n is m		19a. Informant's Name/Relationship (Ty) Denise Ann McDermo				eet and Number Drive			City or Town, State, MD 211	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itsm 27 is marked other then "natural", or itsme 23a or 28a-f show eny injury or other traumatic event, the Madical Examinat must be nutified at once.		20a. Method of Disposition	·		sition (Name of natory or other		Date	-	c. Location - City o	
Baltimore,	ages ant of it: if it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			natory or other.		1/18/2		Bal timor e	
慧	mit. F partme portan r injur		21. Signature of Funeral Service License							pel, P.A	
m	Dermi Depa impo eny i		I John K Ay							nster, M	
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the deat le cause on each line.	h. Do not ent	er the mode of	dying, such as o	cardiac or re	spiratory arres		Approximate Interval Between
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Baltimore, semit. Pages 1 ar begen 1 ar begen 1 ar begen 1 ar mportant of Hema mportant. If them any injury or other nine.	1	20a. Method of Dis		3 □Removal from St	ate	cemetery, cren	sition (Name of natory or other p		Date	20c.	Location - City or	Town, State
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Divi	Certification:	4 Homicide	determ	uned 286 Place 0	, etc. (Speci	nome, farm, str ify) WWL	eet, factory, offic	Θ.	28f Location Silver	(Street a own, Sta	and Number or R	Land Route Number
Division of Vital Rewinding Physicien: The I within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only	1 ☐ Certifyin	ng Physician: To the base	est of my kn	owledge, death	occurred at the	time, date and place	e, and due to th	e tause	(s) and manner a	s stated.
To the H within 24 To the Fi	Medicai	one)		Exeminer: On the bas and manne	r stated.	ation and/or in			urred at the time			
Too coo		29b. Signature and	d title of certifie	She	pv		0.C.	M.E.			il 01, 2	
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Sta Registr		31. Date filed (Mo			gistrar's Sign							_

State of Maryland / Department of Health and Mental Hygiene Reg. No. UU 6 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** Alyce Andresky April 28 10:40 AM 2006 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Brinton Woods Nursing & Rehabilitation Center Sykesville Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F 89 278-16-3806 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturel; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1ÆYes 2□No Funeral Director Maryland Carroll SyKesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Buckhorn Road 21784 1442 USA 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes 2 No Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Andresky Mary Agnes Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Carlin Niece 6675 Mid Summer Night Ct. Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr / 28 2006 Hanover, MD Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Fugreral Service Licensee 1522 Connelley Drive Suite P. Hanover, MD 21076 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) VEUMONIA <2 WKS Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? EGENERATIVE 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has t liractor, page 2 s 1 Yes 24 No 1 ☐ Yes 2 ☐ No funeral diractor, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes / 2 No Other: 4 Defining Home 5 Desidence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Men of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 ☐ Pending after death. investigation 1 Yes 2 No 2 Accident tha 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier sompletely within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)20806 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (000 LIBATY RD UPNB MD ATRICIC SULTE 102: 31. Dete filed (Month, Day, Year) 32. Pagistrer's Signature State Registrar 2006

			1 - For State Registrar	State of Marylan		nt of Health and the of Death		giene 006	13677
	Dhamini	:	1. Decedent's Name (First, Middle, Last)	- 1-10	Frances	E Acho	2. Date of De.	ath Day Year	3. Time of Death
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	Examir	ner	4a. Facility Name (If not institution, give s	. ()	4b. City	Town, or Location of Dea	th	4c. County of Death	
		-	5. Social Security Number 6. Sex		(ast hirthday) If Linds	r 1 Year If Under 24 Hrs	Data of Riv	BALlin	
	Funeral Director			M 20 F	Yrs. Months			y, Year) 1930 MA	nplace (State or Foreign untry)
			Usual Residence of Decedent	1.3			111471	7,1130 1110	(1) VU (10)
	arylar show	_	10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	with the Maryland a or 28a-f show be cotified at	ecto	WELLEVO RETILL	M Sho	ARKVILLE				1 ☐ Yes 2 No
0)	with t	5	10e. Street and Number	00-00 kg	107. 2	Code		10g. Citizen of What Co	untry?
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50	rs after death with the Maryland ', or Items 23a or 28a-f show		1 Never Married SM Married	Armed Forces? 1 ☐ Yes 2 No	If Yes, sp	cify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	
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5-6	be filed within 72 hour tal Hygiene. d other then "naturel" event, the Medical Ex	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Use (Give kind of w life. DO NOT	ork done during most of wo	rking	16b. Kind of Business/I	industry
252	within then.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Howare			OF H	200
	illed Hygid other	a	17. Father's Name (First, Middle, Last)		3/01/18		me (First, Middle,	Maiden Sumame)	1.1
$\mathcal{L}\mathcal{D}\mathcal{C}_{t}$ Maryland		To B	Americo C	idelitasi		Anne	VEN	(TTED.	
lan	C 62 50 50		19a. Informant's Name/Relationship (Type	ne, Print)	19b. Mailing Addres	s (Street and Number or R	ural Route Numbe	er, City or Town, State, Z	ip Code) & alay4
	is 1 and 30 Health Item 27 other tr		3H2H-W NHOL	SR.	Place of Disposition (Na	TORPROAL	YOAO H	J. Ellinger	lacollano
Baltimore,			20a. Method of Disposition ↑★ Burial 2 Cremation 3 □ Re		emetery, crematory or	other place) PR	17 3P	20c. Location - City or 1	own, State
Ħ,			4 □ Donation 5 □ Other (Specify) 21. Synably Funeral Syrvice in ense	TAY	SKMOOD TS	nd Address of Facility	900	LUCKATI	Y TERY LAND
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat			c or respiratory ar	rest,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):				34-12
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9			IF FEMALE:					1	
Box	leath certifi ettending I d for use as	lan/	23b. Was decedent pregnant in the past 12 menths?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3 Ectopic p			23d. Date of delive	very Day Year
o.	the de	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of d 9□ Unknown	eath 5 Other (s	oecify)			,
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<u> </u>	sicien: The law certilicete has t irector, page 2 s	Son					perfor	med death? 2 No 1 ☐ Yes	
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of	Physicie this cert ral direct	L.	1 Yes 2 No	ospital: 1 Inpatient 2 I				ence 6 Other (Spec	ify)
on	iding Ph th. : After th tuneral	t l l	1 Accident 5 Pending investigation	(Month, Day Year)	Injury M	28c, Injury at Work? 1 ☐ Yes 2 ☐ No	20d. Describe ii	low injury occurred	
visi	Atten r dea ector by the	Ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, street, factor		28f. Location (S	Street and Number or Rui	ral Route Number,
ā	tal or	Certification:	4 Nomicide	building, etc. (Specify	v)		City or Tow	m, State)	
	To the Hospital or Attendin within 24 hours effer death. To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and place, in my opinion, death occu	e, and due to the curred at the time, o	cause(s) and manner as	stated. to the cause(s)
	Fo the vithin Fo the comple	Me	29b. Signature and title of certifier	/		c. License number		29d. Date signed (Month)	, Day, Year)
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	1		30. Name and address of person who cor	ppleted cause of death (Item	23a) (Type, Print)	000 1373 Oslen Da	- '4	TONGO	on, /
3	1		FASACU X 31. Date filed (Month, Day, Year)	A Pagietra's Signa	7 7509	Oslen Dr	Soute à	712 MQ.	21204
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	1	For State Registrar	ate of Maryland /		artment of He rtificate of D			glene	6 3678
Q .		Decedent's Name (First, Middle, Last)	D		1		2. Date of De		3. Time of Death
Physicia /Medic	al -	DALE R	BRC	MC			MAY	1,700	06 11:44 1
Examin	er	ta. Facility Name (If not institution, give street Howard County Genera				Location of Death imbia		4c. County	or Death Howard
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th	Birthplace (State or Foreign Country)
Director		081-32-8189 ^{1⊠M} 3	^{2□ F} 81	Yrs.	Months Days	Hours Will.	Feb 24	, 1925	Pennsylvania
and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	ocation				10d. Inside City Limits
Many 9-f sho	to	Maryland Howard		Colum	nbia				1 ☐ Yes 2 XNo
ith the or 286	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of V	
s 23a	erai	10225 Bradley Lane	as Decedent Ever in U.S.	13 1		LO44	ecify Yes or No		d States e - American Indian,
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel", or ttems 23a or 28e-f show event, the Medical Examiner must be notified at	by Funerai	1 Never Married 2 Married	med Forces? ∑Yes 2 □ No Yes, Give ear or Dates1941-62		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2🌠 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White, etc. White
Z15-0036 thin 72 hours af e. en "neturel", or		15. Decedent's Education	1	l6a Dece	dent's Usual Occupa	ation	ina	16b. Kind of Bu	usiness/Industry
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E de la pa	To Be	Lester Guy Brow	n			Edna	May	Kilgor	e
	-	19a. Informant's Name/Relationship (Type, P	Print)	19b. Maili	ng Address (Street a	and Number or Rur	a <i>l R</i> oute Numb	er, City or Town,	State, Zip Code)
		Margie I. Brown/wif			Bradley		lumbia,		nd 21044 City or Town, State
more, Pages 1 ar nent of Hea ont: If item		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remove	val from State	etery, crei	matory or other place	e)			n, Maryland
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Examiner		Sequentially list conditions, b. —	Due to for as a consequen		LER				6 WEEK!
ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	NONI C	The C	tructu	e pu	mona	$\sim D_{\rm C}$	sease 45025
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ds, Fuires than signed	d by						10	Yes 2 ☐ No	3 ☐ Probably 4 ☐ Unknown
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of Vita Physicien: rthis certific ral director,	To B	examiner? 1 Yes 2 No	ital: 1 Inpatient 2 EF	R/Outpatie	ent 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 Res	idence 6 Oth	ner (Specify)
on of ding Phy		27. Manne of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	Ba. Date of Injury 26 (Month, Day Year)	8b. Time o Injury	Wor	yat k? Yes 2 ∐No	28d. Describe	how injury occur	red
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Division of Vital Re within 24 hours after death. To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical Co	(Check only 2 Medical Examinar:	n: To the best of my knowle On the basis of examination and manner stated.	edge, dea n and/or ir	ith occurred at the tir nvestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) and man, date and place,	anner as stated. and due to the cause(s)
To the within 2 To the comple	8		and mainter stated.					29d Date signe	
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1	Σ	29b. Signature and title of certifier	M/MD		29c. Licens	53981	1	MAY,	1 2006
WX X	M	30. Name and address of person who complete the complete that the complete the complete that the compl	oted cause of death (Item 2	23a) (Type	DS	SAGETAL COLOR	7 275	MAY,	

		For Stata Registrar	State of Maryland			Health a	and M		giene Reg. No.	06	13679
	<u> </u>	1. Decedent's Name (First, Middle, Las		-				2. Date of Dea Month	ith Day	Year	3. Time of Death
Physici /Medic		MARTHA	Brooks					APRIL	21	2006	6:35 PM
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* *	(1 ⁽²⁾ -	5. Social Security Number 6. Se			If Under 1 Ye	ar If Under		8 Date of Birth		N/A	lano (Stato or Enraign
Funeral Director		5. Social Security Number 6. Se	1 4		Months Day		Min.	8. Date of Birth (Month, Day	Year)	Cour	place (State or Foreign htry) MARYLAND
* *		Usual Residence of Decedent						12 10	11/2		MAGCANO
ryland how		10a. State 10b. County		own or Loca						1	0d. Inside City Limits
Ma-1-	ctor	M.D.	DA.	LTim	OKE						1 XYes 2 No
ith th	Oire	10e. Street and Number	. 1		10f. Zip Code	9				of What Cour	ntry?
ath w	Funeral Director	613 N. LUZERA			2	1205				USA	
er de item merrin	nue	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	as Decedent of res, specify C	it Hispanic Ori ub <i>a</i> n, Mexicar	gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)		Race - Amend Black, White,	etc.
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thert	1	MARGARET DEA 20a. Method of Disposition		e of Disposit	tion (Name of	OOK U	DURI	BALT	20c Local	ion - City or To	wn State
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permit. Departi		Pullo Alland	tostio	11/2				SERVICE			21213
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Attending refeath. ector: Afte by the fune	atic	2 Accident investigation				□Yes 2□	No				
or Att ter de irect	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	t, factory, office	ce	2	28f. Location (S City or Tow		lumber or Rura	Il Route Number,
urs al			1								
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medicaf Examone)	ysician: To the best of my knowle liner: On the basis of examination and manner stated.	and/or inve	stigation, in m	e time, date an iy opinion, dea	nd place, a oth occurre	and due to the d ed at the time, d	cause(s) an date and pla	d manner as s ace, and due to	tated. o the cause(s)
ithin 2 the ample	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number			29d. Date s	igned (Month,	Day, Year)
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\mathcal{L}_{i}		30. Name and address of person who o			rint)	1442		waru ah			
10			S. Greene of Balt			1201	(1111	nary phy Dr. Rober	+ An	lerson)
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ORIGINAL

	_					artment of rtificate of	Deall		R	eg. No.		
Physici /Medi	1.00	1. Decedent's Name (First, Middle, George Franklin							2. Date of Deat Month April	Day 30	Year 2006	3. Time of Death 1:55 A.
Examir		4a. Facility Name (If not institution, G Gilchrist Cente		mber)		4b. City, Town, TOWSON		of Death			unty of Death timore	County
uneral irector		5. Social Security Number 229-42-2636	S. Sex	7. Age (In y 71	rs. last birthday) Yrs.	Months Day		Min.	8. Date of Birth (Month, Day, Aug. 9	1934	9. Birtho Cour Tenne	place (State or Foreigntry)
28a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltime	ore Count	1	City, Town or Lo						1	l0d. Inside City Limit
a or 28s Lbe not	Director	10e. Street and Number 4207 Halbert A	venuo			10f. Zip Code 21236				_	of What Cour	•
al', or items 23a or 28a-f ehov Evaratrar mval be notilied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece	orces? 2 Mo ve		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔀 No	ban, Mexica	n, Puerto F	cify Yes or No-	14.	Race - Amend Black, White, ecity: Whi	can Indian, etc.
"natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1.2			(Give	dent's Usual Occi e kind of work don DO NOT use retir	e during mo: ed)	st of workin	19		of Business/In	
ed other then:	Be	17. Father's Name (First, Middle, La George Fields		1	bares	s Monager	18. Moth		(First, Middle, Mances E	Maiden Sui	mame))
7 is marked of traumatic eve	2	19a. Informant's Name/Relationship Mrs. Irene Butle				ng Address <i>(Stree</i> Halbert	et and Numb	er or Rural	Route Number	, City or To	own, State, Zip	
)		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	B □Removal from	201	b. Place of Dispo cemetery, cre		lace)	Da		20c. Locati	ion - City or To	own, State
Important: If any injury or pnce.		21. Signature of Funeral Service Lie		-	PC		ess of Facil	ătive	s Funer	al&Cr	rematio	n Ctr. P.
ledical		disease or condition	1001	E (ELEB	ROVAS	CULA	wet	respiratory arre	ENT	-	Interval Between Onset and Death
nysician end the burial-transif	lical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CER	EBP (or as a cons	Sequence of): sequence of): sequence of):	ROVAS	CULF A.R.	DIS	tccid exse	-	9	
inding physician end use es the burial-transif	edical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to d	(or as a cons	sequence of): sequence of): gnancy retal death 3	Ectopic pregnan		Dis	Accid	-	Date of delive	Onset and Death Weolcs Mouths
gned by the attending physician end be detached for use es the burial-transif	by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	b. Due to c d	(or as a consider of pre-	sequence of): sequence of): gnancy etal death 3 [of death 5 [⊒Ectopic pregnan □ Other (specify)	су	VR. P	EASE 23e. Did tot	230	Date of delive Month	Onset and Death Works Mouths Pay Day Year the cause of death?
rate has been signed by the attending physician end page 2 should be detached for use es the burial-transif	Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	b. Due to c d	(or as a consider of pre-	sequence of): sequence of): gnancy etal death 3 [of death 5 [⊒Ectopic pregnan □ Other (specify)	cy gwen in Part	Dis	23e. Did tot 1 Yes 24a. Was al autops perior 1 Yes	23d Dacco use es 2 N n n n n n n n n n n n n n	Date of delivered Month	onset and Death Conset and Death Conset and Death Conset and Death Pay Pay Pay Pay Pay Pay Pay Pa
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BUTLER, GEORGE

			1 - For State Registrar	State of	Maryla		artment of rtificate of				jiene	1 U U b	13681
			1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea	th		3. Time of Death
	Physici		Ma	rjorie L	ismer	Bridges				Month April	23.		10:50P ^M
	/Medic Examir		4a. Facility Name (If not institution, g.				4b. City, Town,	or Location	of Death		7	County of Dea	
			Rockville Nursi	ng Home			Rockv	ille				Montgom	erv
	Funeral			Sex	7. Age (In yrs	. last birthday)	If Under 1 Yea	r If Under		8. Date of Birth (Month, Day	Vanel	9. Bir	thplace (State or Foreign
	Director		215-38-2663	1□M 2∏F	92	Yrs.	Months Days	Hours	Min.	May 16,	19	13	Canada
	<u>p</u>		Usual Residence of Decedent										
	how	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Ba-f	cto		gomery				Asht	on				1 ☐ Yes 2 🛣 No
	or 2	Director	10e. Street and Number				10f. Zip Code			1	0g. Cit	izen of What Co	ountry?
	23a		17910	Pond Ro	ad			2086	1			United	l States
	emet eme	Funeral	11. Marital Status	12. Was Dece	dent Ever in l ces?	J.S. 13. 1	Was Decedent of f Yes, specify Cu	Hispanic Ori ban, Mexicar	gin? (Spento	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
ဓ္ဌ	or I	by Fi	1 Never Married 2 Married	1 ☐ Yes If Yes, Give	θ		1 ☐ Yes 2 🌠 No	Specify:				Specify:	
ë	ural'	D D	3 Widowed 4 Divorced	Year or Da	ites:	1 40 - 5							White
7	"nat	Completed	15. Decedent's l (Specify only highest g	rade completed)		(Give	dent's Usual Occi kind of work don DO NOT use retir	e during mos	t of worki	ing	16b. K	ind of Business	•
7	within	Ę	Elementary/Secondary (0-12)	College (1- 5+	4or 5+)	<i></i>	Area Si	•	cor		7011	Montg	omery lic Schools
2	Hygint, int.		17. Father's Name (First, Middle, Las			1	Alea St	*		e (First, Middle, i			ric schools
an	ould be filed within 72 hours after death with the Maryland Mental typique. arked other then "natural", or Items 23a or 28a-f ehow artic event, the Medical Examinar must be notiliad at	Be											
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene theorems 23a or 28a-f show them 27 is marked other then "natural", or thems 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	ဥ	19a. Informant's Name/Relationship	Arthur L:	Ismer	19h Mailir	ng Address (Stree	at and Number	er or Burs			awson State	Zin Codel
<u>8</u>	d 2 s th an th an trau		Janet Cauffiel		0.36								16
ė,	Heal Heal		20a. Method of Disposition	/ Daugne	20b.	Place of Dispo	Turnham sition (Name of	- 1		-	_	rary Lar cation - City or	
ē	nt of nt of nt of t: ff lt		1 ☐ Burial 2 🛣 Cremation 3		State]	Montgon	natory or other pl	ace)	Apr	ril			
Baltimore,	it. Puritme		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice				rium Ind	seen of English	27,	2006	Bet	nesda,	Maryland
Ba	permit. Pages 1 Department of H Important: if Ite eny Injury or ot goce.)	Test	м003:	35 R	ockville ockville	, Inc Mar	. 300 ylan	0 West M d 20850-	10nt -280	gomery 5	neral Home/ Avenue
			23a. Part1. Enter the disease, or con shock, or heart failure. List enter	plications that ca	used the dea ich line.	ith. Do not ent	er the mode of dy	ing, such as	cardiac c	or respiratory arr	est,		Approximate Interval Between
No.	Physician		Immediate Cause (Final disease or condition				Failure						Onset and Death Recent
1	/Medical		resulting in death)		or as a conse		zarrar						Receire
	Examiner		Sequentially list conditions	b. Core	onary A	Artery	Disease						
7	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conse	quence of):							
$\sqrt{}$	acute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	sien s		rosawing in additity case	Due to (c	or as a conse	quence of):							
876	The law requires that the death certificate be executed site has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dlcal		d									
9	e as	Me	IF FEMALE:								1		
Box	eath certifi ettending p for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 Fet	aldeath 3□	Ectopic pregnan	су			1 4	23d. Date of del Month	livery Day Year
	res that the death igned by tha ette be detached for	sic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of a wn	death 5□	Other (specify)					MORE	Day 19al
O.	d by detac	P.	Part II. Other significant conditions						-	OD - Did to			
Records,	res the						ideriying cause g	iven in Parti.	•				the cause of death?
5	w require been sig should t	ted		Alzheime						1 □ Y€	35 2/	<u>1</u> 100 3∏FI	obably 4 □Unknown
ဝ	law nasb e2sl	Completed	Oste	oporsis,	Osteo:	arthrit	is			24a. Was a autops	v	prior to	topsy findings available completion of cause of
		ပ္ပ								perforr 1 ☐ Yes 2	ned? 2∭No	death?	2□ No
Vital	clen: ertific	Be	25. Was case referred to medical examiner?						of Death	Check only on	6)		
_	Physic this o	ျှ	1 ☐ Yes 2 📉 No	_		ER/Outpatien	I SLI DOM		rsing Ho	me 5 🗆 Reside	ence 6	5 □Other (Spe	cify)
_	ding P	 	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of (Month)	f Injury n, Day Year)	28b. Time of Injury	W	ury at ork?	1	28d. Describe ho	w injur	y occurred	
<u>S</u>	Attendi death. ctor: A y the fu	catl	2 Accident investigate 3 Suicide 6 Could not				M 1	Yes 2 🔲	No				
Division of	or Atten efter deat Director: in by the	Certification;	4 Homicide determine	d 289. Place	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, stre ify)	eet, factory, office	•	1	28f. Location (St City or Town	reet and n, State	d Number or Ri)	ural Route Number,
_	To the Hospital or Attending Physicien: within 24 hours deler death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the	best of mv kn	owledge, death	occurred at the	ime, date an	d place a	and due to the or	ause/s/	and manner as	Stated
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exa	miner: On the ba	sis of examin	ation and/or inv	estigation, in my	opinion, dea	th occurr	ed at the time, d	ate and	place, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			. ^	29c. Licer	se number		2	9d. Dat	e signed (Mont	h, Day, Year)
) lake X	Xa	ia	MI		D104	93			April 2	25, 2006
			30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type.	Print)	5104				TALTI Z	, 2000
	12		John S. Saia, M	.D. 1201	Seven	Locks	Road, #2	202. R	ockv	ille. Ma	rv1	and 208	54-2956
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature	,	, , , ,					
	Registr	ar	MAY 0 2 2006	DEREIA	1 55	A STATE OF THE PARTY OF THE PAR							

		•	For State Registrar	State of N	Maryland		artmen <i>tificat</i>			and Me		giene Reg. No.	06	1368	2
	Physicial		1. Decedent's Name (First, Middle	, Last)		-					Date of Dea Month		Year	3. Time of I	
	Physicia /Medic	_	Carmelo	Barnab							pril		2006 ^{Year}	2:09	рм
	Examin		4a. Facility Name (If not institution Howard County	General Ho			Col	umbi				Но	ounty of Death Oward		
	Funeral Director		5. Social Security Number 212-72-8414	6. Sex X M 2 F 7. A	Age (In yrs. Ia 77	st birthday) Yrs.	If Under Months	1 Year Days	If Under:	Min. N	OV. 8	1928	9. Birth Cou Mar	place (State or ntn) y l and	Foreign
	land Sw	}	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside Cit	y Limits
	Many i-f sho	tor	Md. Howard	d	Co1	umbia								1 🗆 Yes	2 X No
	3a or 28a	Funeral Director	10e. Street and Number 7218 Lasting	Light Way			10f. Zip	Code 2104	5			10g. Citize	эл of What Cou US		
000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23e or 28e-f show other traumatic event, the Mactical Examination and be notified at	by	11. Marital Status 12 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deceder Armed Forcer ed 1 Tyes 2 If Yes, Give Year or Dates		6. 13.1	Was Deced f Yes, spec 1 Yes		ispanic Ori in, Mexican Specify:	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)		Race - Ameri Black, White, pecify: Whi	etc.	
5	72 ho	eted	15. Decedent (Specify only highes			16a. Deced	dent's Usua kind of wo	al Occup	ation during most	t of working		16b. Kind	of Business/Ir	dustry	
7 7	ed within rgiene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. i	Asse	se retired	" er				arehous	е	
מו	uld be file Aental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Michael Barn							ephine	First, Middle, Lucc	Maiden Si Chesi	umame)		
Mar	r 27 E d		19a. Informant's Name/Relations Mrs. Rose Colem				_						Town, State, Zij • 21236		
oditiliore,	Pages nent of ant: If if		20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 4 🗆 Donation 5 🗀 Other (S		CO CO	ace of Dispo metery, crei Holy	natory or c	ther plac		Dat 4-2	27-06		ation - City or T timore,		
Dall	permit. Pa Departmer Important: eny injury once.		21. Signature of Funeral Service	Licerisee		22	Ruck 1050	TOWS York	ss of Facility Son Fu Rd.	neral Towso	Home,	Inc 212	. 04		
	Physician /Medical Examiner	Examiner	23a. Pant 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, п алу, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Athe Due to (or a b. Due to (or a c.	roscie as a consequ	rotic ence of):						1631,		Approximate Interval Betw Onset and D	veen
,007	centificate be executed Iding physicien and Ise as the burial-transit	Ical Ex	resulting in death) Last	d	as a consequ	ence of):									
O. Box oc	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal at time of de	death 3[□Ectopic p □ Other (sp		′			23	3d. Date of delive Month	,	'ear
cords, r	iaw requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant condition	ons contributing to death	n but not resu	ilting in the u	nderlying (ause giv	en in Part I		1		e contribute to No 3 ☐ Pro		
ē L	ician: The law req certificete has been rector, page 2 shou	Completed									24a. Was autop perfo		24b. Were aut prior to codeath?	opsy findings a completion of ca	available ause of
ā	ysician: is certifice director, p	BeC	25. Was case referred to medica examiner?						26. Place	e of Death (Check only o				
0	Physic this ceral dire	ို	1 Yes 2 XNo	Hospital: 1 🗍 Inpa		ER/Outpatie			4 🗆 140				□Other (Spec	fy)	
VISION	fler	atlon:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	gation	njury Day Ye <i>ar)</i>	28b. Time o Injury	M :	28c. Injur Wor 1 🗆	yat k? Yes 2 □		d. Describe l	how injury	occurred		
	al or Attus s after de pi Directo ad in by ti	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of	Injury - At ho etc. (Specify		reet, factor	y, office		28	f. Location (S City or Tov		Number or Rui	al Route Num	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical (29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the be Exeminer: On the basis and manner	s of examinat	wledge, deat ion and/or in	h occurred ivestigation	at the tin	me, date an opinion, dea	nd place, an ath occurred	d due to the	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifie	27				c. Licens)4372	e number				signed (Month		
	H		30. Name and address of person Tariq Mahmoo	who completed cause of	of death (Item	23a) (Type, Back R	Print)	Neck	c Road	d Balt	timore		21221		
25	Sta	ate	31. Date filed (Month, Day, Year)	32. 39	strar's Signat	ture						-			
40	Regist	rar	MAY 0	2 2006	un l	K A	assis.)							
DH	MH 17 Rev 1/2	2001		-	CONTRACTOR OF STATE	-									

DHMH 17 Rev 1/2001

			For State Registrar		Maryland / Depa	artment of Hertificate of D		F	Reg. No 006	13683
	Physicia		Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al		ARNES		45 0% 7	Landing of Dooth	April	28 2066	q: II A M
	Examin	er	4a. Fecility Name (If not institution,		r)	4b. City, Town, or I		•	4c. County of Dea	ın
			UNION MEMORI 5. Social Security Number		Age (In yrs. last birthday)	BALT I If Under 1 Year	IMORE If Under 24 Hrs.	8. Date of Birtl	N/A n 9. Bir	thplace (State or Foreign
	Funeral Director		250 38 5728	1□M 2□F	82 Yrs.	Months Days	Hours Min.	OCT 1	r, Year) C	CAROLINA
			Usual Residence of Decedent						7,1320, 5.	CINCLINI
	how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma	cto	MD. N/A		BALTIMO	RE				1 Yes 2 □ No
	or 24	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23a	ī.	1106 ELBANK			21239			USA	
	er de	Funeral Director	11. Marital Status	12. Was Deceder	s?	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	lf Yes 2∑ If Yes, Give Year or Dates		1 ☐ Yes 2√☐ No	Specify:		Specify: B	LACK
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ha Modical Examiliant, wat be rutified at	ed	15. Decedent's	s Education	16a. Dece	dent's Usual Occupa			16b. Kind of Business	/Industry
215	hin 7;	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4c	life.	kind of work done di DO NOT use retired)	uring most of wor	king		
2	giene giene	No.	7TH			ITOR			WALBROOK	LUMBER
D	d oth	Be (17. Father's Name (First, Middle, L						Maiden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show eny injury or other treumatic event, the Modical Examinational be notified at once.	၉	ARTHUR BARNE					NE CILI		
Mar	12 sh h and 7 le m		19a. Informant's Name/Relationsh AUDREY MCLAUG DIANE BARNES		IGHTER)	-			r, City or Town, State,	
	1 and Healt em 2: ther t		20a. Method of Disposition	(DAUGHTER	20b. Place of Dispo	06 ELBAN sition (Name of		Date Date	ORE MD. 20c. Location - City or	21239 Town, State
5	ages nt of t: If it		tx☐Burial 2 ☐ Cremation		te cemetery, cre	matory or other place	1	F 2006		
altimore,	ertme ortani Injuri		4 Donation 5 ☐ Other (Sp 2 Ignature of Funeral Service L	1 11	KING ME				BALTO,	MD.
Ba	Per Imp eny		Do madin	17/ fee	CA	LVIN B.			RAL HOME	21213
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caus	sed the death. Do not en	$412 \mathrm{E}$. Fitter the mode of dying	, such as cardiac	or respiratory ar	LTO, MD.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		SEPSis					Onset and Death 7 2 hours
	/Medical		resulting in death)	a	as a consequence of):	•				
	Examiner		Sequentially list conditions.	b	pheumo	MIA				96 hours
Y	ed is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence oi):					
	and al-tran	xan	that initiated events resulting in death) Last	c. Due to (or :	as a consequence of):					
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	alE	1	d						
9	uficate g phy as the	Physician/Medical		V						
Box	leath certifica attending ph I for use as t	J.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnancy			23d. Date of de	
	e deat	sicis	in the past 12 months? 1 □ Yes 2 □ No		at time of death 5	Other (specify)			Month	Day Year
P.O.	that the dended by the a	Ph	9 ☐ Unknown Part II. Other significant condition	ne contributing to don't	but not regulting in the	andarbing cause anno	n in Bort i	23e Did to	bacco use contribute t	o the cause of death?
JS,	w requires that the s been signed by th ? should be detache	by	Demen ri A	is contributing to death	Tour not resulting in the c	inderlying cadse give	itair aict.	1 🗆 Y		robably 4 Unknown
ğ	been	etec			داه پرهار			24a. Was		utopsy findings available
He	- m	Completed by	ptriphu	A UNSU	ulay di	5 EASE		autop perfor	sy prior to med? death?	completion of cause of
tal		ပိ	25. Was case referred to medical				26. Place of Dea			s 2□No
>	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Mnpa	atient 2 ER/Outpatie	Otho	-		lence 6 Other (Spe	əcify)
5	ding Phys I. After this funeral di		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I		28c. Injury Work	at ?	28d. Describe h	low injury occurred	
io	Attending ir death. ector: After by the fune	atic	2 Accident investig	ation			′es 2 □ No			
Division of Vital Records,	of or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place of	Injury - At home, larm, st etc. (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or R m, State)	ural Route Number,
	Hospitel 24 hours a Funerel D	ပ္	29a. Certifier	Photoining. To the be	ar of any formula that the area	e constant de la reconstant	The same state of	was been been a	esta de la companya del companya de la companya del companya de la	e week at
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical E	xaminer: On the basis	st of my knowledge, deal s of examination and/or in stated.	ivestigation, in my op	inion, death occu	rred at the time,	date and place, and du	e to the cause(s)
	To the within 2 To the complet	₩.	29b. Signature and title of certifier			29c. License			29d. Date signed (Mon	th, Day, Year)
	- > - 0		> thorny &	m.D.		73	5102		april 28.	2006
	n		30. Name and address of person v			Print)	5102 Street	2	No	10 - O
									INCOME INTO	
	シ		HILAN DON	n.17. 590		Havles '	TYLLY	Part	MOLE ILL	19 11+15
	Sta Registi		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	CHAVILO	TYLLY	Dail	More irei	14119

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death ecedent's Name (First, Middle, Last) ornelius Physician -2006 8:07 A M athanie /Medical Balt or Location of Death give street and numb Examiner more ursing Age (In yrs. last birthday) 5. Social Se curity Numbe Sex 1 M 2 ☐ F **Funeral** Days Months Director Usual Residence of Decedent 10c. City, To 10d. Inside City Limits the Manyland 10b. County vn or Location 10a State or 28e-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Cosvil Director 10g. Citizen of What Country? 10f. Zip Code 2120 7246 Ear 238 Golden Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural', or iteme 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Dapartment of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or iten any injury or other traumatic event, tra Madical Exami 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: δ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retiged) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementar Gecondary (0-12) College (1-4or 5+) Finishe 101 Maiden Sumame. ther's Name (First Name (First, Middle, Last) orne rber State, Zip Code) 19b. Mailing Aver ss (Street and Number or Fit 9406 00 20b Place of Disposition 20a. Method of Disposition Burial 2 Cremation 3 F 3 □Removal from State 21. Signal re of Fune 1 Service dallistown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscieronc cardiovascular Discorse **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 dhknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t firector, page 2 s autopsy 2 No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Injury at Work? 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: / 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00058676 A Poil 28, 2006 Marin L. balett, M.P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main street, state 200, Reisters town. MD 21136 M. D Karen L. Babitt

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Resstrar's Signature

2 2006

			For	State of Maryland			Mental Hygier	e) 6	13685
			Stata Registrar		Certificat	e of Death	Reg. N	lo.	
	Physicia	an.	1. Decedent's Name (First, Middle, La					ay Year	3. Time of Death
	/Medic			COUSIN	T			8 2006	
	Examin	er .	Brightwood N	ursing Home	- Lu	Herville			more
	Funeral Director		213-22-2266	7. Age (In yrs. last 72	Yrs. If Unde Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day 9	33 9. Birt	chplace (State or Foreign buntry)
	and **	-	Usual Residence of Decedent 10a, State 10b, County 1	10c. C(y,	own or Location				10d. Inside City Limits
	Maryl Fied a	ţō	MD Balti	more ti	Keavill	e			1 ☐ Yes 2 No
	with the	Funeral Director	10e. Street and Number	at Dive	10f. Zi	2 1208	10g. (Citizen of What Co	ountry?
	death me 23	neral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	ident of Hispanic Origin? (S porty Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, Whit	
326	be filed within 72 hours after death with the Maryland all Hyglene. And Hyglene dither then "natural", or iteme 23a or 28a-f ehow order then "natural", or iteme 23a or 28a-f ehow event, the Madical Examaina must be notified at	by Fui	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes		Trican, sic.,	Specify: B	lack
ς Ο	72 hou		15. Decedent's E (Specify only highest gr	ducation 1 ade completed)	6a. Decedent's Usu (Give kind of wo	ork done during most of wor		Kind of Business	Industry O
9500-91212	filed within 72 Hygiene. other then "nal	Completed	Elementary/Secondary (0-12)	Conge (1-4or 5+)	life. DO NOT	ise etired)	1	saitimo Scho	xols
Maryland	should be filed within nd Mental Hygiene. marked other then imatic event, I'm M	Be	17. Father's Name (First, Middle, Las	100		18. Mothers Nan	e (First, Middle, Maid	en Sumame)	
Ž	and Menistensis marke	<u>۲</u>	19 Informant's Name Relationship	Typg, Arinto	19b. Mailing Addres	s (Stabet and Number or Ru	raj Route Number, Çit	y or Town, State, .	Zip Code)
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		I homas Cousin	/ Husband	79490ta	rburst Dr.	+ Nesvill	e, mo	21208
altimore,	000		20a. Method of Disposition 1 Burial 2 □ Cremation 3	_Hemoval from State #	e of Disposition (Ne etery, drematory dr	other place)	The In	Location - City or	Town, State
			4 Donation 5 Other (Special Signature of Fundal Service City		ng ton / Va	Address of Facility	ne Funer	Per	irus
ñ	permit. Departr Importe eny inj		Naughn C	. Dreepe	8728	Liberty Rd.		Town, M	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.		de of dying, such as cardiad			Approximate Interval Between Onset and Death
-2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CORONAR		TERY DIS	EASE		Monetty
I	Examiner			Due to (or as a consequent HYPERTE	108 01): EN SION	\checkmark			Moneto
367	D tig	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen					
	xecute and	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequen	nce of):				
8760,	Ilcate be executed physician and s the burial-transit	dical E		_ d					
x 68	entifica ling ph e as th	0	IF FEMALE:	20 · M				4	
80	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl	ath 3 Ectopic p			23d. Date of de Month	Day Year
Ö.	tt the d by the tachec	hysl	9 Unknown	9□ Unknown			-		
Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death certificate be executed in death. ector: After this certificate has been signed by the attending physician and ector. After this certificate bas been signed by the tuneral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying	cause given in Part I.			o the cause of death?
S	aw require s been si 2 should l	Completed					24a. Was an	24b. Were a	utopsy lindings available
Ä	The tav ate has page 2	Com					autopsy performed 1 ☐ Yes 2	death?	completion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	ath Check only one		
_	Physic rthis ral dir	5	1 Yes 2 No	1 Unpatient 2 UEH	VOutpatient 3□□ Bb. Time of	OA Other: 4 Nursing H 28c. Injury at Work?	lome 5 Residence		ecify)
o	nding l ath. r: After e funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		Injury M	Work? 1 ☐ Yes 2 ☐ No			
ivis	or Attendation of the order of the order or orde	Certification:	3 ☐ Suicide 6 ☐ Could not determine		e, larm, street, lacto	ry, office	281. Location (Street City or Town, St		ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Cartifying P	hysician: To the best of my knowle minar: On the basis of examination	edge, death occurre	d at the time, date and place	and due to the cause	n(s) and manner a	s stated.
	the H hin 24 the Fi	Medical	one) 29b. Signature and title of certifier	and manner stated.		9c. License number		Date signed (Mon	
)	N Wild		5 Signature and title of certifier	MD					
	10		30. Name and address of person who	completed cause of death (Item 2:	3a) (Type, Print)	00053150 nhapo no	5.18	te 110	NO
	10		5'h ARUNMAC	A. CEUPTA 96	50 59	ntiago no	ed, co	Cumpi	< 2045-
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	A FROM	(D)			

		1	For State Registrar	State of Mary			t of Health e <i>of Deal</i>			ene 2 ()	06		586
	Physicia		1. Decedent's Name (First, Middle, Last)					1	Date of Death Month	Day	Year	3. Time of 4:30	
	/Medic	al -	Harry M. Clyde Jr. Ia. Fecility Name (If not institution, give st.	reet and number)		4b. City,	Town, or Location		PRIL.	4c. County			
	Examin	71	Baltimore washingto	n MeB. Cei	nter		Burnie			Anne			
	Funeral Director		5. Social Security Number 6. Sex 18	7. Age (li	n yrs. last birth 7	rs. If Under	1 Year If Und Days Hour	s Min. (Date of Birth Month, Day, Y		9. Birthp Coun	lace (State of	or Horeign
			Usual Residence of Decedent		Oc. City, Town	or Lagation		1.00				0d. Inside C	ity Limits
	farylar show	ō	MD Anne Arund		Glen Bu								2 🛛 No
	r 28a-f	Director	10e. Street and Number	ici	GIEII DO	10f. Zip	Code		100	. Citizen of V	Vhat Cour	itry?	
	23a o		127 Martha Road			210		0::0/0	VN-	USA	a Amaria	an Indian,	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event. If we Medical Examiner must be notified at once.	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Dece If Yes, spe		Origin? (Specify ican, Puerto Rica			k, White,		
21215-0036	72 hor	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>		Decedent's Usu (Give kind of wo life. DO NOT u	rk done during r	nost of working	16	Sb. Kind of Bu	ısiness/Ind	dustry	
121	within lene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ast Guai			Ţ	JSA Coa	ast G	uard	
nd 2	e filed al Hyg l other vent.	Be C	17. Father's Name (First, Middle, Last)					other's Name (Fi	rst, Middle, Ma	aiden Surnam	те)		
Maryland	ould to Ment narked	2	Harry M. Clyde Sr.		19h	Mailing Address		Bertha mber or Rural Ro	oute Number.	City or Town,	State, Zip	Code)	
	nd 2 st		Robert Clyde - Sor			-		asadena					
Baltimore,	ges 1 au it of Hea iffitem or othe		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ Re		20b. Place of	Disposition (Na v, crematory or	me of	Date	20	oc. Location -	City or To	own, State	
ţ	permit. Pag Department Important: I any injury o		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	2	Metro (Cremator	V	Apr. 29	. 06 Ba	ltimor	re, M	aryla	nd
Bal	permi Depa Impo any ir		MIN A	ch low	au	7700 Fr	dorick	ciety of Rd. Cate	anerri I I	O MI)	nc. 2122	8	
8760,%	/Medical Examiner physician and the purial-transit	dicai Examiner	23a. Part. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of	rhagi	c Ce	rebvo Va	rs Cula	~ Acci	Cent	Interval Be Onset and E D	
P.O. Box 68	certific nding p	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes 2 \] No 9 \[Unknown \]	Bc. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death	3 □Ectopic p 5 □ Other (s					te of deliventh	ery Day	Year
ds, P.	requires that the death een signed by the atter nould be detached for u	by	Part II. Other significant conditions con	tributing to death but	not resulting in	the underlying	cause given in F	art I.		acco use cons			
\mathcal{DE} I Records,	E S C	Completed							24a. Was an autopsy perform	egt?	Were auto prior to co death? 1 \(\sum \) Yes	opsy findings impletion of 2 \(\text{No} \)	s available cause of
√ Vita	Physician: r this certificinal director,	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient	2□ER/Ou	tpatient 3 D	Other	Place of Death (C			ner (Speci	fv)	
7	g Physier this	 	1 Yes 2 Do 27. Manner of Death 1 Datural 5 Pending	28a. Date of Injury (Month, Day)			28c. Injury at Work?		. Describe how			,,	
HRRY Division	tendin leath. tor: Af the fur	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury		M etreet facto	1 🗆 Yes		Location (Str	eet and Numi	ber or Rur	al Route Nu	mber,
JARRY Divisio	after d Direct d in by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, 31190t, 120to	ry, onico		City or Town,	State)			
I	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination an	d/or investigation	n, in my opinion	, death occurred	at the time, da	te and place,	and due i	o the cause	
	To ti withi To ti	Σ	29b. Signature and title of certifier	Scupp	Anne		DOO6		29	d. Date signe		27-c	.4
	15		30. Name and address of person who con Harvinder Singn	moletadidause of des	ath (Item 23a) 01 Host	(Type Print)			e, MD 2	21061			
		ate rar	31. Date filed (Month, Day, Year) MAY 0 2 20	32, registrar	's Signature		1						

		•	For State Registrar	State of Maryland	d / Depa	artment of H	ealth and N Death		giene Reg. No.	5	13687
Y ST	Physici /Medic		1. Decedent's Name (First, Middle, Last) Charles	(iola	ianni		2. Date of De Month APRIL	Day	Year 2006	3. Time of Death
*	Examin		5. Social Security Number 6. Sex	PKINS HOSPI 7. Age (In yrs. I	last birthday)	4b. City, Town, or Bal	Location of Death 1 Moré If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug. 27	th	9. Birtho	place (State or Foreign
	Director		212-36-9613 Usual Residence of Decedent	M 2LIF 66	Yrs.			Aug. 27	,1939) Ma	ryland
	aryland show dat		10a. State 10b. County		y, Town or Le	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Ma	ecto	MD Balti 10e. Street and Number	more	Pa	arkville 10f. Zip Code			10g. Citiz	en of What Cour	
	3a or	i Di	8321 Old Harford	Road			234		T:	ISA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural" or Itame 23e or 28e-1 show any injury or other traumatic event, the Medical Examinant must be mailined at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? Wyes 2 □ No If Yes, Give Year or Dates:	S. 13.	Was Decedent of Hi If Yes, specify Cubai 1 ☐ Yes 2 ☐ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.))- 1·	4. Race - Americ Black, White,	
5	72 hor	eted	15. Decedent's Educ (Specify only highest grade		(Give	edent's Usual Occupa kind of work done of	luring most of work	ang	1	d of Business/In	
Maryland 21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	Supervi				rtment ond Parl	Of Recreation
<u>م</u>	other	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle			15
ylar	Mente Merked arked	To	Joseph C. Cola	· · · · · · · · · · · · · · · · · · ·			Angela		<u>-</u> _		
Mar	d 2 sh th and th and 7 Is m traum		19a. Informant's Name/Relationship (Tyr. Sandra Colaianni		1	ing Address (Street a					
	s 1 an f Heall item 2 othar	111	20a. Method of Disposition	20b. P	lace of Disp	osition (Name of		Date Pal	20c. Loc	cation - City or To	own, State
Baltimore,	Page nent o ant: If ury or		1 ∰Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Oak	Láw	matory or other place n Cemete	ry 5-3	-06	Balt	imore,	Maryland
Balt	permit Depart Import any inj		21. Signafure of Funeral Service License	N5 Foods	8	2. Name and Addres	ord Roa	d-Park	vill	OF ME	EMORIES 11234 Approximate
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.		icency	g, such as cardiac	or respiratory a	irrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)								Iweek
	Examiner		Sequentially list conditions,	,		oid Lev	Kemi	<u>a</u>			Imonth
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8760,	ate be executed obysician and the burial-transit	dicai	C,	l							
9	sertifica ding pl	/Med	IF FEMALE:	3c. If yes, outcome of pregna	ancv				2	3d. Date of deliv	en
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ideath 3	□Ectopic pregnancy □ Other (specify)			2	Month Month	Day Year
s, P	The law requires that the tte has been signed by thogge 2 should be detache	ed by Pl	Part II. Other significant conditions con	ntributing to death but not res	ulting in the	underlying cause give	en in Part I.	- 11		1	he cause of death? bably 4 Dunknown
Division of Vital Record		Completed						24a. Was auto perf 1 Yes		24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital:	ER/Outpatie	ent 3 DOA Oth	en A Nursina H			i □Other (Speci	fu)
1 of	를 를 들	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Injury		28d. Describe			'77
sion	Attending r death. sctor: After by the funer	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Bay 7 out)	,,		Yes 2 □No				
Divis	P # 5 C	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	(y)			City or To	wn, State)		al Route Number,
	한 수 가 등	edicai		ner: On the basis of examina and manner stated.							
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	Motheles	umi	29c. Licens	s - 000		29d. Date	signed (Month,	Day, Year)
_	13x1		30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type	orkins Ho	spital, 61	0 Nort	h Wo	lfe Street	1,2006 Baltimore Maylund 2128
9	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	asta I				,	
DH	1MH 17 Rev 1/2		MAY 0 2 Z00	to figure is	Tr. Marie						

ORIGINAL

	1.		ate of Maryland	/ Depa		lealth and	-		2006	13688
2.542		Decedent's Name (First, Middle, Last)					2. Date of D Month	Day	Year	3. Time of Death
/sician ledical	_	CYNTHIA Facility Name (If not institution, give stree	CIMINO			1.00	APRIL		2006 County of Death	4.10P M
niner		. Facility Name (If not institution, give stree Brightwood Center	t and number)		4b. City, Town, of Luthervi		atn			County
ıl r	5.	Social Security Number 212-80-4726 6. Sex	7. Age (In yrs. las 2137 52	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		rth ay, Year) 3,1953	9. Birti Co Mar	nplace <i>(State or Foreign</i> unity) yland
10	10	sual Residence of Decedent la. State 10b. County Maryland Baltimore		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
recto	10	e, Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
i Di	3	3401 Chapman Road			21133			Unite	ed Stat	es
by Funeral Director		1 Never Married 2 Married	Nas Decedent Ever in U.S Armed Forces? □Yes 2∏No fYes, Give Year or Dates:	i	Was Decedent of Hilf Yes, specify Cub		(Specify Yes or Nerto Rican, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.
Completed		15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)	on mpleted) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of w d)	vorking	16b. Kir	nd of Business/	Industry
	_		N/A		Disabled	19 Mothads N	lame (First, Middi			
Be		7. Father's Name (First, Middle, Last) Frank Cimino				_	Gean Cir		Sumumoy	
은	1	9a. Informant's Name/Relationship (Type,	Print)	19b. Maili	ng Address (Street				Town, State, 2	Zip Code) 21093
1		Mrs. Doris Gean Bri		7 Lc	ougher Ma	sk Court	t, Unit1)1 Tir	nonium 1	Maryland
	20	Da. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remo	20b. Pla	netery, cre	osition (Name of matory or other pla	ce)	Date		cation - City or	
		4 Donation 5 Other (Specify)	Eva	Trans	alout I			1		ill,Maryla
	-	1. Signature of Funeral Service Licenses	em						Cremation of 2109	on Ctr.P.A.
	li	3a. Part1. Enter the diseater or complications shock, or heart failure. List only one commediate Cause (Final lisease or condition esulting in death)	ause on each line.	URI	= 70	THRIL	IE			Approximate Interval Between Onset and Death
licai Examiner	r	dequentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury nat initiated events c	Due to (or as a conseque		-L RE	TAR	DATIC	n		monetro
Physician/Medi	2	in the past 12 months?	If yes, outcome of pregnan 1 Live birth 2 Fetal (4 Pregnant at time of de: 9 Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of de Month	ivery Day Year
2		art II. Other significant conditions contrib	uting to death but not resul	ting in the i	underlying cause gi	ven in Part I.		tobacco u Yes 2 (o the cause of death?
Completed	_							opsy formed?	prior to death?	utopsy findings available completion of cause of 2 \square No
Be	1 2	5. Was case referred to medical examiner?		11405188			Death Check onl			
ို		1 Yes 2 Hosp 7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 L	R/Outpatie 28b. Time o Injury	of 28c, Inju		g Home 5 Re 28d. Describ			cify)
Certification:		E Could not be	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, s	treet, factory, office			(Street an own, State		ural Route Number,
Medical C			an: To the best of my know On the basis of examinati and manner stated.	, .		4 1 1 1 1 11	A cast a		the territory of the state of	- A- Ab
Me	2	29b. Signature and title of certifier			29c. Licer	se number		29d. Da	e signed (Mon	th, Day, Year)
		> sporte	MD		000	5315	70	AP	RILZ	8 9 2006
		30. Name and address of person who comp Sha www.mara	ideted cause of death (Item 2	23a) (Type	antia	ro no	ed, si	colu	mbis	21045
State		B1. Date filed (Month, Day, Year) MAY 0 2 20	32. Reģistrar's Signat	ure	Sparles					

DHMH 17 Rev 1/2001

					laryland / Dep			Mental Hygien	•	
			1 - For State Registrar			rtificate of		Reg. N	711116	13689
Ì	Physici	20	1. Decedent's Name (First, Middle, La	ıst)		0	1	2. Date of Death Month D	ay Year	3. Time of Death
	/Media		Marvin			-	an	April 2	1 2006	
	Examir	er	4a. Facility Name (If not institution, given	1	· L . I	0 11.	r Location of Death	1.	c. County of Deal	th
	Funeral		Ine Johns Ho 5. Social Security Number 6.	Sex 7. A	OS DI TO I ge (III yrs. last birthday)	If Under 1 Year	nore. Li If Under 24 Hrs.	8 Date of Birth	9. Birt	thplace (State or Foreign
п	Director		00 0005	1 ∑ M 2□F	92 Yrs.	Months Days	Hours Min.	B Date of Birth Month, Day, Yea MAY I 2,	1913 M	ARYLAND
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	Marylan I show	to	MD TALBO	T	TILGH					1 ☐ Yes 2 🖔 No
	h the	irec	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	ountry?
	72 hours after death with the Maryland neturel', or items 23e or 28e-1 show Jical Exactine must be notified at	Funeral Director	21339 FOSTER A	VENUE		2167			USA	
	er deg items	nue	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	 Race - Ame Black, Whit 	
336	urs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Nº WWII KOREA	1 ☐ Yes 2 → No	Specify:		Specify: V	VHITE
21215-0036	72 hor	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup	ation	tking 16b.	Kind of Business/	Industry
121	within lene. then "	mple	Elementary/Secondary (0-12)	College (1-4or		kind of work done DO NOT use retired NELER	d)		JEWELRY	7
	filed Hygi ther int, I		17. Father's Name (First, Middle, Last)	02,	VELEK	18. Mother's Nam	ne (First, Middle, Maide		
an	should be nd Mental marked o	To Be	OSCAR CAPLAN					E GOLDMAN	,	
Maryland	d 2 should th and Mer 7 Is marke treumetic	_	19a. Informant's Name/Relationship					ıral Route Number, City		
	1 and Health tem 27		THOMAS CAPLAN	son	the same of		ER AVENU	JE TILGHM.		
Baltimore,	of of		20a. Method of Disposition 1 Burial 2 Cremation 3			RIDGE	.		_ocation - City or	
Itin	permit. Pag Department Importent: I any injury o		4 □ Donation 5 □ Other (Special Service Lice)				MAY			ESVILLE, MI & SONS CO.
a	Depril Imper		MAST	ONA GO				ROAD MONK		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	i W	Immediate Cause (Final disease or condition resulting in death)	a. Pneu	monia					2 Drey S
	Examiner			Due to (or a	s a consequence of):					100041
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):					1117077761
$\sqrt{}$	te be executed ysician and te burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events	c. Non-1	todakins	Lymph	oma			Syears
,092	oe exe cian a ourial-		resulting in death) Last	Due to (or as	s a consequence of):	/ /				/
687	e 7 e	dical		d						
Box (The law requires that the death certificat to has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		-			23d. Date of deli	ivery
	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No			⊒Ectopic pregnancy ☐ Other <i>(specify)</i>			Month	Day Year
P.0	that the de led by the a detached	Phys	9 Unknown							
	ires the signer	ρλ	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.			the cause of death?
Sor	w require been si should b	letec						24a. Was an		
Records,	The lay	Completed						autopsy performed?	prior to death?	topsy findings available completion of cause of
Vital		O	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 N th Check onlone	o 1 ☐ Yes	2 No
of V	S S	To B	examiner? 1 □ Yes 2 □ No	Hospital: 1 Dinpat	ent 2 ER/Outpatier	nt 3 DOA Oth		ome 5 Residence	6 □Other (Spec	cify)
o u	te i	on:	27. Manner of Death 1 ₩ Natural 5 □ Pending	28a. Date of Inj (Month, D.	ury 28b. Time o ay Year) Injury	f 28c. Injur Wor	y at k?	28d. Describe how inju		
Division	Attending ir death. ector: After by the fune	licat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	a -	ijury - At home, farm, str		Yes 2 □No	28f. Location (Street a	nd Number or Ru	ural Route Number
Οį	Ditte	Certification:	4 ☐ Homicide determined	building, e	ic. (Specify)	eet, factory, office		City or Town, Stai	е)	iai i iodie iadiibei,
	5 5 5 5	edical C	(Check only 2 Medical Exal	nysician: To the besi	of my knowledge, deat of examination and/or in	h occurred at the tin	ne, date and place,	, and due to the cause(s	s) and manner as	stated.
	To the Hosp within 24 ho To the Func completely f	Med	one) 29b. Signature and title of certifier	and manner s	tated.	29c. Licens			ate signed (Month	
\	7 × 10 × 10	-	All 1 1	000 n	Redical Docto		- 600		il 27,	
			30. Name and address of person who		death (Item 23a) (Type.	Print)		- P	'/	
_	10+1		Channing Paller,	The Johns	Hopkins Hos	pital, 600	North Wo	Ife Street, B	altimore	Maryland 2128;
:	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	-1-5				
D1	Registr		MAY 0 2	2005	Comes A A	gode)				
UL	MH 17 Rev 1/2	JUI		A	- 1					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 9 per fh 9855 5-2-06 vt.
State of Maryland? Department of Health and Mental Hygiene

1	-	For State Registrar

13690

		- State Registrar			С	ert	ificate of	f Death	h		Reg. No.		0000
Physicia /Medic		Decedent's Name (First, Midd: IRENE			C	НҮ	ORNY			2. Date of De	27, Day 20		3. Time of Death L2:30 P M
Examin		4a. Facility Name (If not institution 1340 SUDVALE F		umber)			4b. City, Town,	BA	LTIMO	RE	4c. Co	ounty of Death	ALTIMORE
Funeral Director		5, Social Security Number 213-92-7029	6. Sex 1 ☐ M 2 🔀 F	7. Age (In	yrs. last birthd		If Under 1 Yea Months Day		Min.	8. Date of Bi	71 ⁹ 48	9. Birthplac Country Russia	(State or Foreign
ith the Maryland or 28e-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD BALT	/ TIMORE		C. City, Town of		alion					10d.	. Inside City Limits 1 ☐ Yes 2 🎇 No
with the	I Dire	10e. Sireet and Number 1340 SUDVALE R	ROAD				10f. Zip Code	2120	8		10g. Citizer	n of What Country	? JSA
and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. The filed file of 15 should be filed with the "naturel", or Items 23a or 28e-f ehow other traumatic event, the Madical Exand recruit the rigilified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 🌠 Mar 3 □ Widowed 4 □ Divorced	If Yes. G	orces? 2 X No live	r in U.S. 1		as D <i>ec</i> edent of Yes, specify Cu ☐ Yes 2 💢 N			ecify Yes or N Rican, etc.)		Race - American Black, White, etc	
"natur	leted	15. Deceder (Specify only highe	nt's Education est grade completed)	/G	ive ki	ent's Usual Occ and of work don O NOT use reti	e during mo	ost of worki	ng	16b. Kind	of Business/Indus	itry
ed withigh of year them of the war them of the war the	Completed	Elementary/Secondary (0-12)		(1-4or 5+) 2	BEAU		CIAN					TOLOGIST	- i
2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Men	To Be	17. Father's Name (First, Middle, SIMON			SEDL			SAR	RA	(First, Middle		9	SOKOLOVA
and 2 sho ealth and m 27 is m		19a. Informani's Name/Relation: FLORA RADCHENK		HTER			Address (Stre					own, State, Zip Co 21136	ide)
Pages 1 ar nent of Hea int: If item.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		State		rema	atory or other p)ate		tion - City or Town	
permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong.		4 Donation 5 Other (S			NSHE EN		Name and Add	1				BROS., 1	
8228		23a. Part1. Enter the disease, o	or complications that	caused the	death. Do not				OWN F	ROAD -	PIKES\	/ILLE, MC	
Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause on	each line.	tatic							In O	terval Between nset and Death
/Medical Examiner		resulting in death)	Due to	o (or as a co	onsequence of):								
pe jist	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	o (or as a co	onsequence of):								
certificate be executed ding physicien and ise as the burial-transit	al Examiner	thal initiated events resulting in death) Last	c. Due to	o (or as a co	onsequence of):								
rtificate ng physi as the	/Medical	IF FEMALE:	d										
	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		birth 2 in	Fetal death		Ectopic pregnar Other (specify)	ncy			230	f. Date of delivery Month Da	ay Year
ries that signed b	ρ	Part II. Other significant conditi	1 8	death but no		e uno	derlying cause o	given in Pari	t I.			contribute to the	cause of death?
s been s should	Completed	/	100,2	CHU						24a. Was	an a	24b. Were autopsy	findings available
n: The li icate ha										auto perf 1 Yes	ormed? 22 No	death?	letion of cause of
nysiciar nis certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpalient	2 ER/Outpa	tient	3□ DOA C	\ab		me 5 Res		Other (Specify)	
th. After the funderal		27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	/4.4-	e of Injury onth, Day Ye	28b. Tim Inju		28c. In W	jury at /ork? □ Yes 2[_	28d. Describe	how injury o	eccurred	
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Euterial Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u.	Certification;	3 ☐ Suicide 6 ☐ Could	mined 289. Plac	ce of Injury ding, etc. (S	- At home, farm Specify)	stree	et, factory, offic	e			(Street and Nown, State)	Number or Rural R	'oute Number,
e Hospit.	edlcal (29a. Certifier 1 Certifyi (Check only one) 1 Medical	ing Physician: To the I Examiner: On the and ma	ne best of m basis of exa nner stated	amination and/o	eath o	occurred at the estigation, in my	time, date a y opinion, de	and place, eath occurr	and due to the ed at the time	cause(s) an , date and pl	nd manner as state ace, and due to th	e cause(s)
withiu To th	M	29b. Signature and title of certific	ownt,	"פ. את				nse number				igned (Month, Da	y, Year)
4		30. Name and address of person	.ont2, 4	n , D.	23	nc	33 762	41 5	r.ve	Ste	340	Owings .	m. 115 mJ
Sta Registr		31. Date filed (Month, Day, Year MAY 0	2 2006	Poistrar's	Signature		in the						
DHMH 17 Rev 1/20	001					1							

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		nent of Health an	•	giene 0 0 6	13691
•	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) James 4a. Facility Name (If not institution, give su	s Anthony Da		City, Town, or Location of D	2. Date of De Month	2 30 300 4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 1213-52-1224 Usual Residence of Decedent	7. Age (In yrs. last	t birthday) If U Yrs. Mor	Inder 1 Year II Under 24	Hrs. 8. Date of Bir Min. (Month, Da APR 29	N / th y, Year) 9. Bir Co	A thplace (State or Foreign outry) yland
	the Maryland r 28a-f show	rector	10a. State 10b. County Maryland Baltimo 10e. Street and Number		own or Location	Baltimore	2	10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☒ No puntry?
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show sumatic event, the Madical Examinar must be notified at	by Funeral Director	15 Colony Hill Cou	2. Was Decedent Ever in U.S. Armed Forces? 1Yes 2XNo If Yes, Give		21227 Decedent of Hispanic Origin, specify Cuban, Mexican, Fees 2 XNo Specify:	? (Specify Yes or No uerto Rican, etc.)	USA 14. Race - Ame Black, White Specify:	e, etc.
21215-0036	be filed within 72 hour Ital Hygiene. Id other than "natural event, the Medical E.	Completed b	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give kind o life. DO N	Usual Occupation of work done during most of OT use retired) Datcher	working	16b. Kind of Business	White Undustry The Service
Maryland	s 1 and 2 should be file Health and Mental Hyg tem 27 is marked other other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) James Anthony D 19a. Informant's Name/Relationship (Type		19b. Mailing Add		Name (First, Middle aire Mae or Rural Route Numb	Willey	Zip Code)
Baltimore. M	5 = 2 ±		Cynthia Irene Davi 20a. Method of Disposition 1	re MD 2122 20c. Location - City or Paltina	Town, State				
80	permit. Pa Departmen Important: any njury		21. Signature of Funeral Service Licensee Licensee Edward A Grego	ent orchik	22. Nan 299	tory, Inc. 5 ne and Address of Facility Frederick R	Cremation oad Balt	Society of imore, MD 2	MD, Inc.
68760.	Attending Physician: The law requires that the death certificate be executed to find the form of the first this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit to be been signed by the funeral director.	dicai Examiner	23a. Part1. Enter the disease, or complica shock, or heart lailure. List only one transdition to the transdition of the transdition of the transdition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	cause on each line.	CARDIA ace of): Cardio ace of):	INFARCTION		iresi,	Approximate Interval Between Onset and Death / hour
O. Box 6	that the death certifical ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time ol death 9 ☐ Unknown	ath 3 Ector	pic pregnancy er (s <i>pecify</i>)		23d. Date of de Month	ivery Day Year
Becords. P	w requires that been signed b should be deta	۾	Part II. Other significant conditions control 1446ERTENS16N		•	-	10		obabły 4 🗍 Unknown
	n: The ław ficate has t or, page 2 s	e Completed	114 PER LIPIDEMIN 25. Was case referred to medical	7			1 ☐ Yes	prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of
Sion of Vital	anding Physician: The la art: Alter this certificate has he funeral director, page 2	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		one) dence 6 □Other (<i>Spe</i> how injury occurred	city)			
Division	To the Hospital or Attendin, within 24 hours after death. To the Euneral Director: Att completely filled in by the fun	al Certification:	3 ☐ Suicide 6 ☐ Could not be determined 29a. Certifier 1 ☐ Certifying Physic	28e. Place of Injury - At home building, etc. (Specify)			City or To		
1	To the Ho within 24 h To the Fui completely	Medical	(Check only one) 2 Madical Examina 29b. Signature and title of certifier	er: On the basis of examination and manner stated.	and/or investig	ation, in my opinion, death	occurred at the time,	date and place, and due 29d. Date signed (Monto)	to the cause(s)
	di		30. Name and address of person who com					04/30/0	
	Sta Registr		Jerome I. Saybern 31. Date filed (Month, Day, Year) MAY 0 2 2008	32 Registrar's Signature	ө		imere, M	ARYLAND ZI	229

DHMH 17 Rev 1/2001

6-02830 harlice Doughty	' I Sta	Please Type or Print interest of Maryland / Department		ygiene		4 101 101 100	
	1- For State Registrar	Certificate	of Death	Reg N	. 4000	135	9
Physician/ Medical Examiner		Douahty		2. Date of Death Month Day April 26, 2006	Year	3. Time of Death 1545 hrs	
A STATE OF THE PARTY OF THE PAR	4a. Facility Name (if not institution	, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	10	

narrice Doughty		- For State Of Maryland / Department of Healt		ygiene Reg	2006	1369
Physician	/ 1	legistrar Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Examine		4a. Facility Name (if not institution, give street and number) 4b. City, 1	Town, or Location of Death	Month D. April 26, 200	6 4c. County of Death	1545 hrs
		University Hospital Baltin			N/	A
Funeral	5	5 Social Security Number 6 Sex 7 Age (In yrs. last birthday) If Under Month	er 1 Year If Under 24Hrs ns Days Hours Min.	. 8. Date of Birth(MM/DD/YYYY) 9. Birth Foreign	0.0 8
Director	2	217-86-9210 1 M 2XF 32 Yrs.		Aug. 25	1973 COL	ntry) Nd.
any	_	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	5	Md. Anne Arudel Severr)			1 Yes 2 No
or 28a-	Director	10e. Street and Number	Code	10g.	Citizen of What Coun	try?
s 23a o			ent of Hispanic Origin? (Sp		14. Race - Americ	an Indian, Black,
death or item	runeral	1 Yes 2 No	fy Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	· V
s after iral", o	⋧┝	or Dates:	No specify: Occupation (Give kind of v	vork done 116	Specify: 5 C	eck ndustry
72 hour	eted -		rking life. DO NOT use reti		- 1	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12 0 Las	porer		tacte	ry
filed all Hygined other	S P	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Mai	den Surname)	/
		19a. Informant's Name/Relationship (Type, Print) (mother) 19b Mailing Address	Street and Number or F	Rural Route Numbe	r, City or Town State,	Zip Code)
MD nd 2 sho alth and m 27 is		Mrs, Elua White 18513 20a, Method of Disposition 20b. Place of Disposition (Nar	Moneer.	Drive 2	Oc. Location - City or	M. 21144
ore, ges l a tof He : If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place		3/2006	100000	ulua Md
. ⊑ d g g a b l	2	4 Donation 5 Other Specify: 21. Signature of Funeral Sergice Licensee 22. Name and	Address of English		Harrisao	whe, ma
Balti permit Departi Importi injury		Joseph L. Kuss 1905eph	NOTTH AVE.	130 ITD:	tome P.A.	2
Physician /Medical	1	23a. Partil Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.		or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Narcotic (Heroin and Fentanyl) Due to (or as a consequence of):	intoxication			3000
		Sequentially list conditions, b				
1	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ited 1 ansit		events resulting in death) Last Due to (or as a consequence of):				
760, Greate be executed g physician and the burial - transit	Medical	X UNPENDED AMENDED item#23a,PII,27,28a-f,	,perME,g855,5/12	2/06 TT		
68760, certificate be nding physici		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year
Box 687(ne death certifica the attending pl	iciar	past 12 months? 4 Pregnant at time of death 5 Other (Spe		anoy	THOTAL E	
C the dea by the a ached fo	Physician/	1 Yes 2 No 9 ✓ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
res that the signed by	ক্র	Cocaine use		1 Yes	2 No 3 Prob	ably 4 Unknown
ords, F	Completed			24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
Recol The law cate has	ĕ			perform 1 Yes 2		s 2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death all Director: After this certificate has been so led in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3	26 Place of Death (Check		esidence 6 Other	
of Viring Physic	읽	1 Yes 2 No	28c. Injury at Work?	28d. Describe ho		·
ion (tending eath tor: A)	ation	Natural 5 Pending Investigation Fnd 4/26/2006 Fnd 3:00PM	1 Yes 2 X No	unk		
Division of Vospital or Attending Physical or Attending Physical or Attention after death present of filled in by the funeral	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factor	y, office building, etc.	28f. Location (Str Baltimore	eet and Number of Ru te). 1905 Wilhe	ral Route Number, City In Street
lospita f bours uneral		4 Homicide 29a. Certifier 1 Continue Physician: To the best of my knowledge death occurred at the	ne time, date and place, an			ted
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in m and manner-state(s)				
F 3 F 3	ž		9c. License number	1	29d. Date signed (Mo.	nth, Day, Year)
			O.C.M.E.		April 27, 2006	
•		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 2	1201		

State 31. Date filed (Month, Day, Year)
Registrar

111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 13693

		I-For State Registrar		Cert	ificate of	Death			Re	eg No.		IU IUUJ
Physicia		Decedent's Name (First, Middl	e,Last)						Date of Deat Month	h Day	Year	3. Time of Death
ledical Examir	ner	Kayla	L. Dalto	n					April 22, 2		I eai	1106 hrs
and the same of th		4a. Facility Name (if not institutio Baltimore Washingtor			4	b. City, Town, or Glen Burnie		of Death			unty of De e Arunc	
Funeral	-	5 Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Yea	ar If Unde	er 24Hrs.	3. Date of Bir	th(MM/DD/		Birthplace (State or
Director		None	1 M 2 XF		Yrs.	Months Day		Min.	12 02	OF	Fo	reign Country) Maryland
	ŀ	Usual Residence of Decedent				4 20			12-02-	-05		<u>Maryland</u>
any	ı	10a. State 10b. County		10c. City, T	own or Locati	on						10d Inside City Limits
* .	_	MD		G1e	en Burr	nie						1 X Yes 2 No
Maryland 28a-f show 1 at once.	윉	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What C	ountry?
ith the Maryland 23a or 28a-f sho notified at once	Director	438 West Cou	ırt			2106	1		USA			
with the s 23a		11. Marital Status		edent Ever in U.S		s Decedent of Hi	spanic Orig					merican Indian, Black,
leath	Funeral	1 X Never Married 2 M	arried Armed For	rces?	If Y	es, specify Cuba	n, M exican	, Puerto Rio	can, etc.)		White, etc	۵.
ifter de I ^r , or	by F	3 Widowed 4 Div	orced If Yes, Give Year or Dates:		1	Yes 2 X No	specify:			Spe	cify:B1a	ack
ours a		15. Decedent's Education (Spe		e completed)		t's Usual Occupa ost of working life				16b. Kind	of Busine	ess/Industry
21215-0036 Id be filed within 72 hours after denial Hygiene. anriced other than "natural", event, the Medical Examiner.	ompleted	Elementary/Secondary (0-12) NOne	College (1-	-4 or 5+)	during in	None	J. DO 1101	ase remod				
003 withir iene. er th	Ĕ					-						
15-0 filed Hyg d oth	Ö	17. Father's Name (First, Middle, Kereen Gallmo:							ne (First, Middle, Maiden Surname)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event. the Medica	ωĮ	19a. Informant's Name/Relations			19h Mailine	Address (Stre			1-2-1-5-1-6	ober City o	r Town S	tate Zin Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٦	Ruth Dalton				Vest Ct.				D. 210	061	
Te, land land Heal		20a Method of Disposition 1 X Burial 2 Cremation	2 Pomoval fra		ace of Dispos ematory or oth	ition (Name of ce ner place)	emetery,		ate	20c. Loca	ition - City	y or Town, State
MOF Pages I nent of I annt: If	Ш	4 Donation 5 Other S	Lancard Comment		enwood			4-28-	-06	Wash	ingto	on, D.C.
Balti permit Departir Imports injury o	1	21. Signature of Funeral Service			22. N	lame and Addres	s of Facility	Mar	shall'	s Fun	eral	Home
m 8 2 5 5		& P Mai	shall		4	217 9th.	St.	N.W.	Washi	ngton	, D.	C. 20011
Physician /Medical		23a. Part V Enter the disease, or failure. List only one cause	complications that ca on each line. a Sudden					ardiac or re	espiratory arr	est, shock,	or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)					Death					
			Due to (or as a	consequence of)	:							
	됼	Sequentially list conditions, if any, leading to immediate		consequence of)	:							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С.	consequence of)								
uted Id ansit		events resulting in death) Last	d.									
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8760, tificate be ng physici as the buri	₹	IF FEMALE:		outcome of pregn						23d Da	ate of deli	very
687 certific	an/	23b. Was decedent pregnant in the past 12 months?	LIVEDI		2 Fe	tal death 3	Ectopi	c pregnanc	у	Mo	nth	Day Year
Box 6 e death cert the attendired for use a	Sic	1 Yes 2 V No 9 Un	known g Unkno	ant at time of dea	5 Ot	her (Specify)						
.O. Box 6 that the death ce led by the attend detached for use	Physicia	Part II. Other significant conditions			sulting in the u	inderlying cause	given in Pa	art I.	23e. Did to	obacco use	contribute	e to the cause of death?
tal Records, P.O. crian: The law requires that th certificate has been signed by ector, page 2 should be detach	ğ								1 Ye	s 2 N	3 🔲 I	Probably 4 🗸 Unknown
ds, equire een si	etec								24a. Was			e autopsy findings available
COr law r	Completed			· · · · · · · · · · · · · · · · · · ·			-	-	autop	rmed?	deat	1
Division of Vital Records, tal or Attending Physician: The law requirers after death at Director: After this certificate has been siled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.		25. Was case referred to medica	1			26 Plac	e of Death	(Chook on	1 Yes	2 No	1 🗸	Yes 2 No
Vital Pysician:	Be	examiner?	- Heavital:	npatient 2	FR/Qutpatient		Other 4	Nursing I	_	Residence	6 0	Other
n of Virting Physic	<u>۲</u>	1 Yes 2 No 27 Manner of Death	28a Date	of Injury	28b. Time of I		ury at Work		Bd. Describe	_		
onding ath	ţį		ding Fnd //	, Day,Year) /22/2006	Fnd 11:	00 am ¹□	Yes 2 X	No 1	ınk			
r Atta r Atta ter de irecto n by t	fica		sugation	e of Injury - At ho			building, e	tc. 28	Bf. Location (Street and	Number of	r Rural Route Number, City
Division ospital or Attend hours after death meral Director:	Certification:		ermined (Specify)	Found a	t home				alen Bur	ille, M	D was	. court
Hosp 24 hc Fund stely f		29a Certifier 1 Certifying F	Physician: To the bes	t of my knowledg	e, death occu	rred at the time,	date and pl	ace, and du	ue to the cau	se(s) and m	anner as	started.
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use.	Medical		aminer: On the basis of and manner s	of examination ar tated	nd/or investiga				he time, date			
	Σ	29b. Signature and title of certification	er	11			se number					(Month, Day, Year)
		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	W1. 2			0.0	.M.E.			April 2	3, 2006	
		30. Name and address of person Jack Titus MD. De	n who completed caus puty Chief Medic			nn Street, Ba	altimore	MD 212	01			
	tate											
Regis		88AV 0.9	2006	College A	K for	we						
		MHI U A			0							

06-02784 Ronald D'Angelo

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea No Registrar . Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ **Medical Examiner** Fmidio D'Angelo 1733 hrs Ronald April 24, 2006 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 24 Manor Spring Court Glen Arm **Baltimore County Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8, Date of 8irth(MM/DD/YYYY) 9, 8irthplace (State or Davs Director 214-50-5854 1 X M 2 58 03/24/1948 Country) MD Vrs Usual Residence of Deceden 10a State 10c. City. Town or Location any 10d Inside City Limits tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Baltimore Yes 2 X No Glen Arm Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 24 Manor Spring Court 21057 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, 8lack Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 2 X No Yes 4 X Divorced Give Yea Yes 2 X No specify: Specify White ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of 8usiness/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. Baltimore, MD 21215-0036 4 Businessman Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Emidio D'Angelo Be Assuntina Chiodi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike D'Angelo - son 7033 Copperwood Way, Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State mportant: 4/29/2006 Chesapeake Crematory Donation 5 Other Specify Beltsville, MD Signature of Funeral Service 22 Name and Address of Facility CAFA, Stephen D. Lohrmann, 8717 Green Pastures Drive, PA Towson, M00986 21286 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Oxycodone intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical tending physician a X UNPENDED X AMENDED item#11,23a,27,28a-f,perME,g855,5/24/06 TT the Hospital or Attending Physician: The law requires that the death certificate behin 24 hours after death Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending 1 Live birth Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? signed b ş Yes 2 No 3 Probably 4 ✔ Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate 2 No Yes 2 1 🗸 Yes 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natura Director: / 1 Yes 2 X No Pending Fnd 4/24/2006 Fnd 4:47 PM 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State 24 Manor Spring Court Glen Arm, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide To the Funeral determined (Specify) found at home Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 25, 2006 eros. . Name and address of person who confi eted cause of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 Month April **Physician** Raymond A. Dicus 21. 7:27 A M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 1**x** 2 ☐ F 216-42-4620 60 Yrs. 06-22-1945 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County XXYes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1009 Rectory Lane 21211 12. Was Decedent Ever in U.S. Armed Forces? tx[32Yes 2 □ No if Yes, Give Year or Dates: 1969 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steiff Silver Engraver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: if Item 27 is marked oth eny jury or other traumatic event 908g. Lee Patrice Hoffman John Walter Dicus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21211 Deborah Dicus 1009 Rectory Lane Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Speqify) Maryland Veteran Cemetery 5/1/06 Garrison Forest, MD 21. Signature of Funeral Service Lidens e 22. Name and Address of Facility Burgee-Henss-Seitz Funeral F 3631 Falls Road Baltimore, Funeral Home, Inc. altimore, MD 21211 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) 100 ardid Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month signed by the at d be deteched to 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1ahetes 3 robably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No 1 Yes 2/ No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D23076 wen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buttonne Kichny 31. Date filed (Month, Day, Year) 32 Registrar's Signature 2000 State MAY 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For Stete Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Mell IONA 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TIMORE HINGION MEDICAL Tir Ukoer 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🛚 F Days 80 Yrs. 200-16-6635 PA Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at MD Anne Arundel Severn 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 231 Carbarn Road 21144 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No ff Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2x ☐ No Baltimore, Maryland 21215-0036 þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hardware Secretary & Manager 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tant: if Item 27 is marked ott jury or other traumatic even Be Jeheil Noble Mary Ellen Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sandra Iverson/daughter 10132 Crystal Falls Dr., Hagerstown MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Important: i any injury o once. Glen Haven Cemetery |5/5/2006 Glen Burnie, MD 21061 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home Sign sure of Funeral Service Licenses M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ntartion myocand **Physician** /Medical Examiner thuns Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit to the Hospitei or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the e 9 Unknown 9 Hillnknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 □ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only onle) Hospitaf: 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Dale filed (Month, Day, Year) State MAY 0 Registrar 2006

DONACH

			For State Registrer	State of Marylar				lealth a <i>Death</i>	nd Me		giene Reg. No.	UUb	1369) 7
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) R OBLE R 4a. Facility Name (If not institution, give s		Don	_ `		JR . r Location of	Death	Date of Dea Month	Day 2 ~	County of Dea		Death O PM
	Funeral Director		Usual Residence of Decedent	7. Age (In yrs.	Yrs.	If Under	or 1 Year Days	If Under 2 Hours	4 Hrs. 6. Min.	Date of Birth (Month, Day \pri	13,	1937 9. Bi	rthplace (State or country) Pennsylv	ania
	with the Marylar s or 28s-f show be ov Illied st	Funeral Director	Md. Baltimore 10e. Street and Number 2402 Burridge Rd	e Bal	timore		ip Code 212	34			10g. Citi	izen of What C	10d. Inside City 1 □ Yes country?	
980	igas 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23s or 28s-1 show or other traumatic event, the Modral Examiner must be nuitled at	by		12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:			edent of H		in? (Specif Puerto Ric	y Yes or No- an, etc.)		14. Race - Am Black, Wh Specify:		
Maryland 21215-0036	filed within 72 ho Hygiene. other than "natur ent, the Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life. Super	kind of w DO NOT	ork done use retire	during most			Bui		s/Industry Inspecti	on
aryland	2 should be fill and Mental His marked oth aumatic even	To Be	17. Father's Name (First, Middle, Last) Robert Donal 19a. Informant's Name/Relationship (Ty.)	pe, Print)				Marga and Number	aret ror Rural R		r er, City o	r Town, State,	Zip Code)	
Baltimore, M	Pagas t and and one of Health int: If item 27 iny or other tra		Barbara Rehak/ Da 20a. Method of Disposition 1 Disposition 2 Cremation 3 DR 4 Donation 5 Other (Specify)	20b. I	7201 Place of Dispo cemetery, cre dens o	osition (Namatory of	ame of other plac	ce)	Date	re, Md	20c. Lo	cation - City o		
■ Balti	permit. Pages Department of i Important: If its any injury or o		21. Signature of Emeral Service License 23a. Part1. Enter the disease, or compli	ications that caused the dea		Ruc 105	Yor		unera Towson	l Home n, Md.		264	Approximate	
H H	And the buriat-transit	I Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	quence of):	Cell	Corú	horlar	4	lug			Interval Betwonset and D	
.O. Box 68760,	law raquires that the death certificate ba exacuted as basin signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a	aldeath 3[⊒Ectopic ⊒ Other (:		,				23d. Date of do Month		ear
0	aw raquires that i is baan signed by 2 should be deta	Completed by Ph	Part If. Other significent conditions con COYUNGY QUIC	ntributing to death but not res	sulting in the u	underlying	cause giv	en in Part I.		24a. Was	res 2 an	□No 3□F	to the cause of de Probably 4 Uu	nknown
f Vital Records,	Physician: The lav this certilicate has ral director, page 2	To Be Com	25. Was case r ferred to m dical examiner?	(a) ·] ER/Outpatie	nt 3□ [DOA Oth	0.0		1' Yes Check only o	rmed? 2 □ No ne)	death?	s 2 No	use of
Division of	Attending death. ictor: After	Certification:	27. Magner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 27. Accident 4 Homicide 4 determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Speci	28b. Time of Injury	М		yat k? Yes 2 ☐ N	10	d. Describe h Location (S City or Tow	Street an	nd Number or F	Rural Route Numb	oer,
Õ	Hospite 4 hours Funeral ely fille	ledical Cer	29a. Certifier 12 Certifying Phys	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, dear	th occurre	d at the til	ne, date and	d place, and h occurred	due to the	cause(s)	and manner a	as stated. Le to the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier Ship as a unit of the certifier of	K		2		e number			29d. Da	te signed (Mor	2006	
	10+1 Sta Regist		30. Name and address of person who co	GANT / 600 32. Registrar's Sign	MURT	H 4)6		STREE	T	BACILI	MOR	E F	10 2128	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL Vear **Physician** FRANCIS Χ. DENBOW 1:00 A. M 26, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 1319 MALBAY DRIVE LUTHERVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-22-1946 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours XX M 2 F 60 MARYLAND 213-46-1144 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Exercitorermust be notified at MD. BALTIMORE LUTHERVILLE 1 Yes 2 X 0 Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 1319 MALBAY DRIVE 21093 U. S. A. Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Menfal Hygiene. ant: If item 271s merked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 \sum No 1964-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 Mo WHITE Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1967 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. LAW FIRM Elementary/Secondary (0-12) College (1-4or 5+) MECHANICAL TECHNICIAN 12 YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DENBOW DAVID MCKEWEN HELEN R. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1319 MALBAY DRIVE, LUTHERVILLE, MARYLAND, 21093 JANE L. DENBOW (WIFE) item 27 l other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial XXCremation 3 Removal from State 05-02-2006 TOWSON, MARYLAND, 21204 5 permit. Page Department of Important: If eny injury or ance. HILLTOP SERVICE CORP. 4 ☐ Donation 5 ☐ Other (Specify) 1050 YORK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 (R. G. RUTH) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANCREATIC CANCER HONTH **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-fransit The law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Yea 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown s been signed to should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes XX No page 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home XXResidence 6 Other (Specify) 2 1 ☐ Yes XX No 1 Inpatient 2 ER/Outpatient 3 DOA After the 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1XXNatural 5 Pending 1 Yes 2 No r death. investigation 2 Accident Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 | Homicide hours after within 24 hours a 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) <u>8</u> 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APRIL 27, 2006 027730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMONE, MD. MD 6569 N. CHALLET COVIEN 32 Registrar's Signature 31. Date filed (Mont State Registrar

		1	For State Registrer	te of Maryland / Depa	artment of Healt		ntal Hygie Reg.	2006	13699
	Physici	an	Decedent's Name (First, Middle, Last) ANA		Elsave	2.	Date of Death Month	Day Year 30 700 C	3. Time of Death 20.35 M
	/Medic Examin	er	4a. Facility Name (If not institution, give street a The Johns Hofkins 5. Social Security Number 6. Sex 142-134-6392	7. Age (In yrs. last birthday)	4b. City, Town, of Local	nder 24 Hrs. 8. urs Min.	Date of Birth (Month) Day, Ye	ar) Coui	place (State or Foreign http:) MANUf
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	2	-16-191		Od. Inside City Limits
	h the Man	Director	10e. Street and Number	BALT AM 508	10f. Zip Code		10g.	Citizen of What Cou	1 KYes 2 □ No
	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show Jigal Evanirer must be notified at	Funeral D	Am	s Decedent Ever in U.S. 13. led Forces?	2125 Was Decedent of Hispani If Yes, specify Cuban, Me			14. Race - Americ Black, White,	
15-0036	n 72 hours a' "natural', or	þ	_ \ If Y	es, Give ar or Dates:	1 ☐ Yes 2 No Special	ecify: most of working		Specify: W	dustry
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Maryland	2 should be and Mental is markad of aumatic evi	To Be	Mchaned Your 19a. Informant's Name/Relationship (Type, Pri		ing Address (Street and N	Umber or Aural R		DHAM ity or Town, State, Zip	Code) 11203
-	of Health of Health if Item 27 or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	20b. Place of Disposemetery, cre	S. FRESIDE / osition (Name of matory or other place)	Dale	BACTI 200	Location - City or To	own, State
Baltimore	permit. Pag Department Important:: any injury o		* 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee)	PM01452 6	2002 Cenctery 2. Name and Address of F 2818 E. B				ral Home PA
	Physician /Medical Examiner	er	Sequentially list appointment	e on each line.	nter the mode of dying, suc			EN I	Ap roximate Interval Between Onset and Death Agrange States State
,8760,	The law requires that the death certificate be executed the has been signed by the attending physician and take as the burial-transit bage 2 should be detached for use as the burial-transit.	edical Examiner	that initiated events	due to (or as a consequence of):					
.O. Box 6	that the death certific ed by the attending p detached for use as I	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
Q	w requires that been signed b should be dete	þ	Part II. Other significant conditions contributing	ng to death but not resulting in the t	underlying cause given in F	Part I.	23e. Did tobac	co use contribute to t	he cause of death? pably 4 Unknown
Il Records,		Completed	, 15.8				24a. Was an autopsy performed	prior to co death?	ppsy findings available impletion of cause of
Vital	Phyaician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othor	Place of Death (C			
ot	Phya this ral dir	- T	1 Yes 2 No	1 D Inpatient 2 ☐ ER/Outpatie Date of Injury 28b. Time of	ant 3 DOA 41		5 Residence I. Describe how i	e 6 □Other (Special niury occurred	(y)
	ding I th. After tuner	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes	2 🗆 No			
Division	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Certification;	a Could not be	. Place of Injury - At home, farm, st building, etc. <i>(Specify)</i>	treet, factory, office	28f	Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
	To the Hospital within 24 hours a To tha Funaral I completely filled	edicai	(Check only 2 Medical Examiner: One) and	To the best of my knowledge, dea n the basis of examination and/or in d manner stated.	nvestigation, in my opinion	n, death occurred	at the time, date	and place, and due t	o the cause(s)
)	. 4	M	29b. Signature and title of certifier	Medical Docto	29c. License num	000	No	Date signed (Month,	006
_	10		30. Name and address of person who complete Russell Hales	600 N.	Wolfe St.	B41	timore	MARYLA	W 21287
	Sta Regist	ate ' rar	31. Date filed (Month, Day, Year) MAY 0.2.2006	32 Registrar's Signature	cite			/	

06-02520 David Frye

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Month Medical Examine 0825 hrs April 13, 2006 David Frye 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death Eastern Correctional Institution Somerset 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** Months Days Hours Min Director 1 X M Country) PA 230-80-3375 Oct 11 1961 44 Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No 23a or 28a-f show notified at once. Somerset Westover hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 30420 Revell Neck Road 21890 Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 X No Yes 4 X Divorced Widowed If Yes, Give Year Yes 2 X No specify white ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) es 1 and 2 should be filed within 72 of Health and Mental Hygiene Baltimore, MD 21215-0036 12 Chicken Farmer Agriculture 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) event, t Be Thomas Kuty Susan Munkasey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Jacquet/mother 19595 Dutchmans Lane Unit 602 Easton, MD 2160 of Disposition (Name of cemetery, Date 20c. Location - City or Town, State MD 21601 crematory or other place) Burial 2 Cremation 3 Removal from State tant: 5 X Other Specify: Import Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 nee Baltimore, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician List only one cause on each line /Medical Cardiac arrhythmia due to cardiomegaly Immediate Cause (Final disease ^rxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate use. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical item#23a,27,perME,g856,6/20/06 TT XUNPENDED AMENDED Division of Vital Records, P.O. Box 68760, the attending physical IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of has l performed? death? certificate page ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other₄ Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 this 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No within 24 hours after death To the Funeral Director: Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) OCME April 14, 2006 al 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

31. Date filed (Month, Day, Year)

MAY 0

2006

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32 Registrar's Signature

				For Amend Item#5 per IH 6855 5/12/06 Department of Health and Mental Hygiene 3 7 1 - State Registrar Certificate of Death Reg. No.
		Physici /Medic		1. Decedent's Name (First, Middle, Last) Ohr Oack C. Fisher 2. Date of Death Month Day 2006 2: 00 PM
		Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County o
		Funeral Director		220-34-SHO 11 M 2 F 67 Yrs. Months Days Hours Min. (Month, Day, Year 38 Maryland Usual Residence of Decedent
		ith the Marylan or 28a-t ehow se notified at	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 ZHO
		23a	Funeral Director	1807 Bear Creek Dr. 21056 USA 11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No- 14, Race - American Indian,
400	5-0036	ours after rel', or Ite Exemine	ρ	1 Never Married 2 Married 1 Ves 2 No If Yes, Give Year or Dates:
7 /	21215-	2 22	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Administratory 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) C; +12en5 Nursing Home
	Maryland 2	1 and 2 should be filed within Health and Mental Hygiene. am 27 is marked other then ther traumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last) Harry E. Fisher Jr. S. Elizabeth Akehurst
0		s 1 and 2 sho of Health and itam 27 is m other traum		19a. Informant's Name Plationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2, 10 So 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition of Disposition (Name of Dispositi
12910	Baltimore,	t. Page rtment o rtant: it njury or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signalur of Fun tal Service Licensity 22. Name and Address of Facility Evans Funeral Home
J	Ba	Dermi Depa Impo eny Ir		23a. Part 1. Enter the disease, or compiler tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
	7	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Me fus fatic Melunismus. Due to (or as a consequence of):
	X	8 8	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
77	7,092	ate be executed hysicien and the burial-transit		that inflated events c. resulting in death) Last Due to (or as a consequence of):
18800	O. Box 68	ne death certific the attending p thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Nocoo	ds, P.O.	uires that the signed by the detection	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Not 3 Probably 4 Unknown
	of Vital Records,	The law requir te hes been s age 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
J.	Vital	ysician: The is certificete he director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
7sher, John	ion of	utending Physical death.	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury at Work? 1 Tyes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 1 Tyes 2 No
sher	Division	p ag ⊑	Certification:	3 Suicide 6 Could not be determined 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ü		Ne Hospital	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		To the within 2 To the complete	W	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/30/06c
		6+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DY . BODY IN 1 (002 South Attood Vd. Suite 200 Belary mb
		St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 0 2. 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month A-DT Year **Physician** 13,10 M Apidas 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balt more Good SAMARITAN teos Dital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 250F 21430506b Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2□No Be Completed by Funeral Director CHRAPAD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number D.S.A 91917 2000 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify. WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) iayrsi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ELEANOR GILBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTITORS 14003 EDWARD J. FARRY ANDAR 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State □Donation 5 □ Other (Specify) 900F 22. Name and Address of Facility F MIMORIZS
EXAMS HAREON ROAD ARXIVIL 21. Son ture of Fune all ervice Lip naee 213014 Jox 1 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comp salrons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AUDXIC Due to (or as a consequence of): 1915 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): Examine Due to (or as a consequence of): Ician/Medicai Physi P þ Completed Certification:

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humanimum. Division of Vital Records, P.O. Box 68760

/Medical

Funeral

Director

traumatic event, the Madical Examinar must be notified at

or Iteme

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othing any injury or other traumatic event, pdgs.

Pnysician

/Medical

FFEMALE: :3b. Was decedent pregnant in the past 12 g/onths? 1 □ Yes 2 g/d No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
art II. Other significant condition	s contributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
URINAUT TR	act infect	iou, ac	eete	1 ☐ Yes 2	□No 3□Probably 4☑Unknown
renal fail	Diabetu	Meli	ritery	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
5. Was case referred to medical	THE STATE OF THE STATE		26. Place	of Death (Check only one)	
examiner? 1 ☐ Yes 2 ØNo	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐	DOA Other: 4 Nur	sing Home 5 Residence	6 □Other (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident investiga		28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju	ry occurred
3 Suicide 6 Could no determin		nome, farm, street, fact ify)	ory, office	28f. Location (Street a) City or Town, State	nd Number or Rural Route Number, e)
	Physician: To the best of my kn xaminer: On the basis of examin				

Res ooo

Apr-29,2006

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAY 0 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Ministry Callo DALNITSKI, 5601 Loch RAVOU BLUEL, Baltimore, MD, 21239 32. Registrar's Signature Coastes

		•	For State Registrar	State	of Marylan		artment of H tificate of L		-	giene Reg. No.	06	13703
	÷0		1. Decedent's Name (First, Middle,	Last)	-				2. Date of De	ath	Vans	3. Time of Death
	Physicia /Medic		Frederick Orwin	Francis					April	Day 25	2006	11:15 A.M
	Examin		4a. Facility Name (If not institution,	give street and nu	imber)		4b. City, Town, or	Location of Deat			ounty of Death	
		11	Manor Care Rux				Towson				ltimore	
п	Funeral			5. Sex ∱ }M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	v. Year)	9. Birthp	place (State or Foreign ntry)
	Director		217-26-1396 Usual Residence of Decedent	2111	85	115.			March 8	3,192	1 Nor	th Carolina
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	IOd. Inside City Limits
	Mary -1 ah Iled	to	Maryland Balti	hore	Ti	monium						1 ☐ Yes 2∭ No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citize	on of What Cour	ntry?
	h with	aiD	68 Northwood Dr	ive			21093			Unit	ed Stat	es
	dea	Funerai	11. Marital Status	12. Was Dec	edent Ever in U		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No	- 14	I. Race - Americ Black, White,	
9	or It		1 Never Married 2 Marrie		2 🗌 No		1 □ Yes Ž O ŽNo	Specify:	to riloan, oto.,		Specify: Whi	
Ö	hours ural',	d by	3 Widowed 4 Divorced	Year or I	Dates:							
21215-0036	itled within 72 hours after death with the Maryland Hyglene. ther than "natural", or Itema 23a or 28a-f ahow int, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	rking		of Business/In	
12	withi ene. than	mc	Elementary/Secondary (0-12)	College	(1-4or 5+)		inist	,		Blac	ck and	Decker
0	filed w Hygier other th	BeC	17. Father's Name (First, Middle, La			1		18. Mother's Nar	me (First, Middle,	Maiden S	umame)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-1 ahow aumatic event. The Medical Examiner must be notified at	To B	Kenie Lester F	rancis				Jettie	May Chui	cch		
ary	ges 1 and 2 should t of Health and Men If itam 27 is marke or other traumatic		19a. Informant's Name/Relationshi	p (Type, Print)			g Address (Street					,
	and alth		Mrs. Mary E. Fr	ancis (W		_	Northwood	Drive,	Timoniur	n Mar	yland,	21093
ore	ges 1 ar 1 of Hea If itam or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	3 □Removal from		cemetery, crer	sition (Name of natory or other place	(e)	Date		ation - City or To	
Ĕ	Pages ment of i ant; If it, jury or o		* 4 □ Donation 5 □ Other (Spe		EA.	ans Fw	neral Cha	pel Apri	1 27,20)6 F	orest H	ill, Marylan
Baltimore,	permit, Page Department Important; If any injury or once.		21. Signature of Funeral Service Li	censee		re:	Name and Addres	ss of Facility	Funerala.	nd Crei	motion Ct.	1. P.A
	00 F 9 0		- FORM	The In		9	325 York	Road T	imenium	Mary	land.	21093
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause on	caused the deat each line.	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory as	rest,		Approximate Interval Between Onset and Death
	Physician	6 1	Immediate Cause (Final disease or condition resulting in death)	_a_PN	EUMC	MIM						weko
8	/Medical Examiner		rooding in additi)	Due to	(or as a conseq	uence of):	is Tale (211 22 21	1004	Nicc	Acc	10005
		er	Sequentially list conditions if any, leading to immediate	b. Due to	(or as a conseq	uence of):	KTNE	o Childre	0/4/C]	שטוע	Noe	gas
	uted I Insit	min	cause. Enter Underlying Cause (Disease or injury that initiated events			,						0
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8760	cate be executed physician and the burial-transit	dical		d.								
9		0	IF FEMALE:									
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0		sici	1 Yes 2 No	4□Preg 9□Unk	inant at time of d nown	leath 5□	Other (specify)	 -			WORKI	Day real
۵.	that the death hed by the atter detached for u	Ph	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I	23a Did t	nhacco use	e contribute to t	he cause of death?
Records,	3c 3c	d by	Severe dus	pha c1	2 with	1	on 10-a	sorat	in 10			
Ö	w require been sign should t	etec	#6 1:00	200	Ilaha			0				
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	ician: Th certificate rector, pag	e Co	25. Was case referred to medical						1 Tes	27 No		2□ No
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o	nding ath. r: Afte e fun	atio	1 Dending 1 Dending 2 Dending 2 Dending 1 Dending		nth, Day Year)	Injury	M 1	k? Yes 2 □ No				
Division of	Atte	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flat	e of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (: City or Tox	Street and	Number or Rura	al Route Number,
ā	tal or	Cer			211191 010. 1000011				0.1, 0.	, O.a.o,		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifica completely illed in by the funeral director,	edical	(Check only 2 Medical E	xaminer: On the	basis of examina	owledge, death	n occurred at the tin	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) a	nd manner as s lace, and due to	tated. the cause(s)
	the thin 2 tha mplet	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		29c. License				signed (Month,	
	Wil To		250. Signature and title of certifier	$O \Gamma$	7000	0.				Dan!		00 (-
	{ 1		- Pendad	_10	we v		Driet)	~~~ + =		74	wold	000
	e+1		Lenda OD R	to completed car	use of death (Iter	n 23a) (Туре, ПоБМ	Print) Charles	est Si	uste 200	B	ecto M	W21204
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Signa	ature 🚜	Acasto 2	_, _, u			•	
ņ.	Registr		MAY 0	2 2006	RASIAL	15	The state of the s					

		For State Registrer		Maryland / Depa Ce	artment of F		R	leg. No.	5 13/0
Physicia	ın	1. Decedent's Name (First, Middle, Last, Annemarie		Frank			2. Date of Dea Month	Day Y	a. Time of Death
/Medica		4a. Facility Name (If not institution, give			4h City Town o	r Location of Death	April	25, 2006	
Examine	er 	Greater Baltimor			Towson			Balti	
Funeral Director		5. Social Security Number 6. Sec		Nge (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth Month, Day Sept 7,	1931	Birthplace (State or Fore Country) GETMANY
pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lim
Maryla febo	5	MD Balt:	imore	Towson	JO4(1011				1 ☐ Yes 2 🔯
r 28s-f ehow	rect	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of Wha	at Country?
23a or	٥	409 Virginia Ave	., Apt 30	01	2128	6		U.S.A	١.
8 0	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? X No	Was De cedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
natural	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	ness/Industry
i within liene. r than	Completed	(Specify only highest grad	College (1-4o	/ife.	kind of work done of DO NOT use retired	during most of work	ing	Garment	Industry
tal H d ott	To Be (17. Father's Name (First, Middle, Last) Johan	Frank			18. Mother's Name Johann			ot known
and and sum		19a. Informant's Name/Relationship (Ty Michael Cossenting	•		ng Address (Street				
of Health Item 27 other tr		20a. Method of Disposition	1e-son	20b. Place of Dispo	5 Zackery			, NC 282	
permit. Pages 1 Department of H Important: If Ite eny injury or ot once.	-	1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Hilltop S	matory or other place Serv. Corp	p 4/2	8/06	Towson,	MD
Depar Impor		21. Signature of Funeral Service Livens		1 1	1050 York	Rd., Tow	son, MD	21204	Home, Inc.
executed on and ial-transit	dical Examiner	23a. Pan1. Enter the disease, or complishock, or heart failure. List only of timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a consequence of): Is a consequence of): Is a consequence of):		evuvo Parku			Interval Between Onset and Death
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w requires that been signed b should be dete	۾	Part II. Dther significant conditions con		but not resulting in the u		en in Part I.	23e. Did to	5/	ite to the cause of death? ☐ Probably 4 ☐Unkno
The faw ate hes b	Completed						24a. Was a autops perform	sy prio med/? dea	re autopsy findings availa r to completion of cause of th? Yes 2 \sum No
stcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only or	10)	
% v 5	2	1 ☐ Yes 2 No	lospital: 1 X Inpa			4 L 11013119 110		ence 6 Other ((Specify)
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e Hospital 124 hours e Funerel letely filled	edicai C	29a. Certifier (Check only one)	sician: To the bes ner: On the basis and manner:	st of my knowledge, deat of examination and/or in stated.	h occurred at the tim vestigation, in my of	ne, date and place, pinion, death occurr	and due to the c red at the time, d	ause(s) and manne ate and place, and	er as stated. If due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	dou		29g. Licenso	number 732	2	9d. Date signed (A	Month, Day, Year) 5/2006
10	30	30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type.	Print) Char	les st	Balti	'wore, o	nd. 2120
Stat Registra	10.5	31. Date filed (Month, Day, Year) (MAY 0 9 20		strar's Signature	and I		-		

DHMH 17 Rev 1/2001

			For State Registrar	State of Mary		artment of H		-	iene 006	13705
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h _.	3. Time of Death
	Physici /Medic		Annie Gregory					APRIL	21, 200	6 145 QM
	Examin		4a. Facility Name (If not institution, give s Maryland Gel	neral He	ospital	Baltin	r Location of Death	1xty	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 343-18-6168	7. Age (in 83	yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 16,		rthplace (State or Foreign country) unk
	land ow		10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
	Mary I eh	ţ	MD	1	Baltimor	e				1X Yes 2 No
	ith the Marylan or 28a-1 ehow	irec	10e. Street and Number		- GIVINOI	10f. Zip Code		10	0g. Citizen of What C	country?
1	th wit	Funeral Director	700 W. 40th Street			21211			USA	
1	eme eme	lne.	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an. Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh	
36	n 72 hours after death w "natural", or Iteme 23a	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	
9	hour tural	ed b	15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Busines	hite
21215-0036	within 72 hours after death with the Maryland iene. 'than "natural', or Iteme 23a or 28a-f ehow It e Medical Examinational be rigitlind at	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work	unk unk	TOD. KING OF BUSINES	unk
Maryland 2	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If itam 27 le marked other than "natural", or Iteme 23a or 28a-f ehov or othar traumatic event, it a Medical Examinational be multilled at	To Be C	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	unk
ary	should and Men e marke urmatic	_	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health a am 27 le		Paul Bloomberg/exe	cutor	9881	Broken La	and Pkwy.	#303 Co	lumbia, MI	21046
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If itam 27 any injury or othar tr. once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location - City o	r Town, State
Balt	permit. Pages Department of Important: If it any injury or o		21. Signalury of Funeral Secrice License			2. Name and Addre		d 655 W.	Baltimore	Street
П			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the		ter the mode of dyin	g, such as cardiac			Approximate Interval Between
	Pnysician	1	Immediate Cause (Final disease or condition	House	Lena	e Fai	/URE			Onset and Death
	/Medical Examiner	į ľ	resulting in death)	Bue to (or as a con	nsequence of):					
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rds	quires in sign	q pa						1 ☐ Ye	s 2 No 3 F	robably 4 Wunknown
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R	The law ate has page 2	E			-			autops perform 1 Yes 2	ned? death?	
Vital	ysiclan: The is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on		
of V	Physiclan: this certific ral director,	2	1 ☐ Yes 2 the No	lospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing Ho	ome 5 Reside	nce 6 Other (Sp	ecity)
n o		iuo:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Wor	k?	28d. Describe ho	w injury occurred	
Sio	Attanding or death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	One Bless of laive.	At home form		Yes 2 □ No	39f Location (Ct	reet and Number or F	Zuen I. Claude Aliumbaa
Division	l or A after Dirac	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	reet, factory, office		City or Town	, State)	nurar Houte Number,
_	To the Hoepital or Attanowithin 24 hours after death To the Funeral Diractor: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my ner: On the basis of exa and manner stated.	/ knowledge, deat mination and/or in	th occurred at the tin	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a ate and place, and du	is stated. le to the cause(s)
	Nithin Fo the	Me	29b. Signature and title of certifier	0 "	115	29c. Licens	e number	25	9d. Date signed (Mor	ith, Day, Year)
	->-0			exercun 1	M.D.		89551	/	4/21/	06
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print) Ch	MARI	land	General	Hospital
	Sta	- 6	31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	will !		, -0	2,2.1-7000	
	Registi	ar	MAY 0 2 200	O Part Sales	A. S. S. S. S. S. S. S. S. S. S. S. S. S.	-				

		1	For State Registrar	State of Marylan		ment of H			giene	6	1370)6
St		100	1. Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of D	Death
	Physicia		Irn	ia Leah G	ilbert			April	29, 200	Year)6	5:40	A^{M}
	/Medic Examin		4a. Facility Name (If not institution, give s			c. City, Town, or	r Location of Deat		4c. County		7.10	
	L. Adilliii	Ci Jaka	8200 Pulaski High	nwav T # 11		Ra1	timore		1	Baltin	noro	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		Under 1 Year	If Under 24 Hrs		th	9. Birthp	lace (State or	Foreign
	Director		217-26-1475	M 2₫F 77	Yrs.	onths Days	Hours Min.		0, 1929	Mary	land	
	0		Usual Residence of Decedent									
	how		10a. State 10b. County	10c. Cit	y, Town or Locati	on				1	0d. Inside City	
1		to	MD Baltimor	e Bal	timore						1X☐ Yes	2 [] No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	ntry?	
	oeann wiin ine Maryland me 23a or 28a-fehow rinkal be nollied al	ai	8200 Pulaski Hwy.	T # 11		21237			US.	A		
	E E E	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was	Decedent of H	ispanic Origin? (S	Specify Yes or No to Rican, etc.)	- 14. Ra	ce - Americ		
۰	or It		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	i	Yes 24 No	Specify: wh:)	y: whi		
2-003p	be filed within 7.2 hours after dean win the warylan tall Hygiene. Ital Hygiene. Id other than "natural", or Iteme 23a or 28a-f show event, ite Medical Examiner must be notified at	d by	3- Widowed 4 □ Divorced	Year or Dates:								
ភ	nati	Completed	15. Decedent's Edu (Specify only highest grade		16a. Decedent (Give kind	s Usual Occup	ation during most of wo d)	rking	16b. Kind of B	usiness/Ind	dustry	
V	within 72 ene. than "na	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemak		1)		TT			
N.	tygie her t		8 17. Father's Name (First, Middle, Last)		Homeman	KEL	18 Mother's Na	me (First, Middle	Home	779		
yland		Be		C						110)		
200	should be ind Mental marked umatic ev	၉	William H. Montg		100 14 17 1	(0,		len Watk		O 7	0-4-1	
100	V 42 = 90		19a. Informant's Name/Relationship (Ty		911			ural Route Numb				
	Health Health em 27		William A. Gilber		LUU8 (uantri]	L Way Ba	ltimore,	Marylai 20c. Location			
0	rages 1 and neut of Head int: If Item inty or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	Place of Disposition cemetery, cremator	ory or other plac	(e)	Date	20c. Location	· City or 10	JWII, State	
<u></u>	LIY THE TA		4 □Donation 5 □Other (Specify)					1, 06	Paltins	ore, l	Marylar	1J
Baltimore,	Depermit. Depertrimports any infe		21. Signature of Funeral Service Linens	60		ame and Addre		of Mar	vland .	Inc.		
_	405 a a		MIN ACI	Mangu	_ 29	9 Frede	rick Rd	of Mar Catons	ville; 1	MD_21:	228	
			23a. Part. Enter the disease, or compleshock, or heart failure. List only or	ications that care ed the deat ne cause on each line.	h. Do not enter ti	he mode of dyin	ig, such as cardia	c or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
F	hysician		Immediate Cause (Final disease or condition	Metasta	tic E	Breas	t Ca	nces	3		Olisot and D	Odin
	/Medical		resulting in death)	Due to (or as a conseq	uence of):							
	Examiner		Sequentially list conditions.)								
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	dence of).							
	acute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last									
/60,	ate be executed hysicien and the burial-transit	ũ	resulting in death) cast	Due to (or as a conseq	uence or):							
200	ate p hysic the b	Ilcai		d						-		
200	death certificate e attending physical for use as the	Physician/Med	IF FEMALE:									
Š P	ath co	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Feta	Ideath 3 Ec	topic pregnancy	/			ate of delive onth	-	ear
		Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of d 9 Unknown	eath 5∐Ot	ther (specify)					,	
J.	at m d by 1 etach	Phy	Part II. Other significant conditions con		ultime in the conde		an in Dani I	22a Did	obacco use con	tribute to th	ha asuca of de	nath?
ທົ່	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions con	ambuting to death but not res	uning in the unite	llyllig cause giv	entin Fanti.		Yes 2 No			
5	v requir been si should	ted						'	103 2010		7451y 4 [[51	
Records,	> LI (S)	Completed						24a. Was	psy	prior to cor	psy findings a mpletion of ca	
_		Con						perfo 1 ☐ Yes	2 IZ No	death? 1 ☐ Yes	2 No	
Vital	certificate rector, pag	Be (25. Was case referred to medical examiner?					ath Check only				
	d is	ို	1 Yes 2 No		ER/Outpatient	3□ DOA Oth	er: 4 Nursing I	Home 5 Resi	dence 6 Ot	her (Specif	(y)	
	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occu	rred		
<u> </u>	Attending ir death. ector: After by the fune	atic	2 Accident investigation			M 1 🗆	Yes 2 □No					
DIVISION	r Attend ter death irector: by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street,	factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rura	al Route Numb	20 <i>1</i> ,
Ξ.	9 = 0 =	Cer										
	Hospitel 24 hours a Funerel tely filled	cai	29a. Certifier 1 Cartifying Phy (Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, death oc	curred at the tir	ne, date and plac	e, and due to the urred at the time.	cause(s) and m	anner as st	tated. o the cause(s)	
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai	one)	and manner stated.								
	To To	2	29b. Signature and title of certifier	1.		29c. Licens			29d. Date signe			
	!		Jasmu 1	Pare		$\perp D$	00614	180	May 1	, 2006	6	
	15		30. Name and address of person who co									
	12		4920 Campbell Bou			21236						
A ST	Sta		31. Date filed (Month, Day, Year) MAY 0 2 2	32. Registar's Signa	ature	100						
	Registr	aı	mai V Z Z	UUU KARASAS -	150							

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of	Marylan		artment of rtificate of		Mental Hy	giene Reg. No.	06	13707
4	Physicia	20	1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath Day	Year	3. Time of Death
	/Medic			rawryck					April	25'	h 2006	10:56 AM
	Examin	er	4a. Fecility Name (If not institution	•	oer)		4b. City, Town	or Location of Dea	ath '		unty of Death	
			OAK CREST 5. Social Security Number		Age (In vrs.	last birthday)	DAL I If Under 1 Yea	I MORE	rs. 8. Date of Bir	+h	ALTIMO	olace (State or Foreign
	Funeral Director		203-05-6543	1 Ճ M 2□F	86	Yrs.	Months Day		Jan,	31, 19:	20 Cour	PA
	2		Usual Residence of Decedent		1.0							
	arylar ehow	<u>.</u>	MD Ba	1+1	10c. Cit	y, Town or Lo					1	1 ☐ Yes 2 No
	28a-1	Director	10e. Street and Number	ltimore			Essex			10 0''	- (11111 - 1 - 2 - 1	
	death with the Maryland rme 23a or 28a-f show	ā	715 Clover	Ave			10f. Zip Code				of What Cour	ntry ?
	me 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13.1			(Specify Yes or No	USA - 14.	Race - Americ	can Indian,
0	or Iter	Fun	1 ☐ Never Married 2 ☐ Marr			ľ			(Specify Yes or No erto Rican, etc.)		Black, White,	
000	rel', o	1 by	3	If Yes, Give Year or Date	9S:		1⊡Yes 2⊠XN	o Specify:		Sp	ecify:Whi	te
ה	natu dical	Completed	15. Decedent (Specify only highes	's Education It grade completed)		(Give	dent's Usual Occ kind of work don	e during most of w	rorking		of Business/In	
7	Mithin then then	m	Elementary/Secondary (0-12)	College (1-4	or 5+)	Prov	oo NOT use retii 7 ing Pr	essman	(rown	, Cork	& Seal
7	Hygie ther ther	ပိ	12th 17. Father's Name (First, Middle,	Last)		1		18. Mother's N	ame (First, Middle	, Maiden Sui	mame)	
yland	id be ental ked o	To Be	Felix Gawry						ia Buck			
2	nd M mar	F	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address (Stre		Rural Route Numb	-		Code)
Mar	ss 1 and 2 of Health a item 27 le other trace		Robert Gawr	yck / so	n	3 Hc	olly Br	ook Cou	rt Balt	imore	e MD ∶	21236
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I Important: if fine 27 is marked other then "naturel", or freme 23a or 28a-1 show eny injury or other traumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition	2 Dameust from Ct	20b. F	Place of Dispo	sition (Name of natory or other p	ace)	Date		ion - City or To	
Saitimor	Pag ment: If ury o		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _i		HC	DITA H	lill Ce	metery	5/2/06	Balt	cimore	e MD
Z Z	permit. Departi Importi eny inj		21. Signature of Funeral Service	_icensee //		//	. Name and Add		300 Mace	e Ave	. Bal	to. MD
_	40 E S 0		K. W	your	rell			Funera	al Home	of E	ssex	21221
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the deat th line.	o not ent	er the mode of d	ring, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death)	_ aA	SCV	0						YEW1
36	/Medical Examiner		rooming in sommy	Due to (or	as a conseq	uence of):						/
<u>.</u> E.	20	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq	uence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
5	exec an an rial-tr	Еха	resulting in death) Last	Due to (or	as a conseq	uence of):		···				
00/0	The law requires that the death certificate be executed are has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai		d								
0	ing pt	Med	IF FEMALE:	T								
200	ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Feta	ldeath 3□	Ectopic pregnar	су		23d	. Date of delive Month	ery Day Year
5	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□Unknow	nt at time of d m	leath 5□	Other (specify)					22,
ŗ	that the sed by detact		Part II. Other significant condition	Ins contributing to dea	th but not res	ulting in the u	nderlying cause of	liven in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
cords,	urres I sign Id be	d by	Denendia	, his (reph	rechar	vy		1 🗆	Yes 2 □	6 3 □ Prob	oabiy 4 Unknown
5	w req shou	Completed					1		24a. Was	an 2	4b. Were auto	posy findings available
ב	he tas e has age 2	dmo							auto perfo	ormed?	death?	ppsy findings available mpletion of cause of
	en: I	0	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only o	2/21No	1 🗆 Yes	OZ NO
>	nysici iis cei direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp	patient 2	ER/Outpatier	t 3 DOA		Home 5 ☐ Resi		Other (Specif	y)
DIVISION OF	ng Pr fter th		27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		ury at ork?	28d. Describe	how injury or	curred	
2	eath. or: A the fu	Certification:	2 Accident investig	ation			M 1	Yes 2□No				
2	or At fter d birect in by	rti	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Place of	f Injury - At hi , etc. <i>(Specil</i>	ome, farm, str y)	eet, factory, offic	9	28f. Location (City or To		umber or Rura	al Route Number,
J.	ours a erel [29a, Certifier 1 Certifyin	a Physician: To the h	ast of miller	wlades dest	1 Conserved -1 11	timo data end al-	on and due to the	anusals' =:	d manner :	tatod
	To the Hospitel or Attending Physicien: The law within 24 hours after death within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical one)	g Physician: To the be Examiner: On the basi and manner	is of examina	tion and/or in	vestigation, in my	opinion, death oc	ce, and due to the curred at the time,	date and pla	imanner as s ice, and due to	taled. o the cause(s)
	Vithin To the	Me	29b. Signature and title of certified		ms -		29c. Lice	nse number		29d. Date si	igned (Month,	
	ON		> /	1	11.0		Da	3115		April	28	th 2006
	4		30. Name and address of person	mo completed cause	of death (Item	n 23a) (Type,	Print)	0 , ,		1111		
	U		Jeth Longson		s wal		,	Per Eville	mo	2123	4	
100	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9 2	006 Market	istrar's Signa	ature	Les .					

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Gaddy 00 AM Apry 2006 Janet /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marning side of Sarry Hill 5. Social Scourity Number (6. Sex Parkville Battimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Months 228-42-3855 71 Yrs. Director 10, 1934 Washington D.C Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 United States 8800 Old Harford Road 21234 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 10 10 1f Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) A and M International Printer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be G. Adeline Masemer Paul C. Dutrow ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19004 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health al Important: If Itam 27 is any Injury or other trea <u>once</u>. 130 East Princeton Road, Bala Cynwyd Pennsylvania Mr. Glen Gaddy (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition competery, cromatory or other classes | 4/39/06 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful, Alternatives Funeral & Cremation Ctr. P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licenseg Đ) Terry 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Endstag Parkinson **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate has After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0059423 April 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCK ROVERBIVD POB#303 Battomore, MD 21239 Feinse 5601 31. Date filed (Month, Day, Year) 32 Registrar's Signature 2006 Registrar MAY 0 2

			For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment rtificate	of Health of Dea	n and N th	Mental Hygi	ene 0 0 6	13709	
	Dhusiai		1. Decedent's Name (First, Middle	Last)						2. Date of Death		3. Time of Death 8: 17F'	_
	Physici /Medio		Ethel May Gay			<u>.</u>	1				,		_
ł	Examir	er	4a. Facility Name (If not institution, Saint Joseph	give street and num	i Cent	er		wn, or Location				Pothimore	
	Funeral Director		220-14-8039	6. Sex 1 ☐ M 2 X ☐ F	7. Age (In yrs. I 81	Yrs.	If Under 1 Months [Year If Und Days Hour	der 24 Hrs. rs Min.	8. Date of Birth April 1	Year)1925	Birthplace (State or Foreign Maryland	,
	pus *		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits	
	Maryl	ŏ		imore		rbutus						1 ☐ Yes 2 🛣 No	
	a or 28a	i Director	10e. Street and Number 3300 Benson Av	e. Apt.	122		10f. Zip C			10	g. Citizen of Wha	-	
္က	permit. Pages 1 and 2 should be lied within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hyglene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ADDS.	by Funerai	11. Marital Status 1 Never Married 2 Marrie	Armed For ed 1 ☐ Yes If Yes, Giv	2 (X)No e		Was Deceder If Yes, specify	Cuban, Mexi	ican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
	hours lural',	d b	3 ☐ Widowed 4 ☑ Divorced	Year or Da	ites:					Τ,			_
1215-	within 72 ene. then "nel	Completed	15. Decedent' (Specify only highes Elementary/Secondary (0-12)	college (1	-4or 5+)	(Give life.	dent's Usual (kind of work DO NOT use Liver	done during ri retired)	nost of work	ing	6b. Kind of Busin	ness/industry	
2	illed thygi other	Be C	17. Father's Name (First, Middle, L	ast)				18. Mc	other's Nam	e (First, Middle, M			-
اها	uld be Aenta rked tic ev	To B	William H. A.	Breitenba	ch			Et	hel I	. Zoelle	r		
Mary	ind 2 sho eith and N 27 ie ma er frauma		19a. Informant's Name/Relationsh Diana Skuhr, d							a/ <i>R</i> oute <i>Number</i> , 1timore,		ate, Zip Code) 229	
Baltimore, Maryland 21215-0036	Pages 1 a nent of He int: if item iry or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 4 □ Qonation 5 □ Other (Sp		State Mea	lace of Dispo emetery crea COWI 10	sition (Name natory or othe Ige Men	oriace) iorial		Date 2 04-20-(16	0c. Location - Cit E1krid	y or Town, State ge, MD	
Balt	permit. Depertr imports any inje		21. Sona ure of Funeral Service L	2 bac	cahoù	1	328 Su	ılphur	Sprin	me, Inc. g Rd. A	rbutus,	MD. 21227	
F	nysician		23a. Part 1. Enter the disease, or shock, or heart failure. List of the shock of th	only one cause on e	ach line.					or respiratory arre		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequARDIAL	uence of): INFA	RCTIO	N					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consequ								
8760,	ate be executed hysicien and the burial-transit	ai Exar	that initiated events resulting in death) Last	C	or as a consequ								
687	ficate p physics the	edical		d									
D. Box	The law requires that the death certificate be executed are has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		inth 2 ☐ Fetal ant at time of de	death 3	Ectopic preg Other (spec				23d. Date of Month		
0.	s that the	by Phy	Part II. Other significant conditio	ns contributing to de	ath but not resi	ulting in the u	nderlying cau	se given in Pa	art I.	23e. Did tob	acco use contribu	ute to the cause of death?	
rds	w requires been sig	ed b								1 ☐ Ye	s 2□No 3[Probably 4 Unknown	
Division of Vital Records,	The law requate has been bage 2 shouk	Completed								24a. Was an autopsy perform 1 Yes 2	prio leal? dea	re autopsy findings available ir to completion of cause of th? Yes 2X No	
<u> </u>	sten: artifice ctor. p	Bec	25. Was case referred to medical examiner?					26. PI	lace of Deat	h (Check only one			
<u>~</u>	hysic this ce al dire	၉	1 ☐ Yes 25 No			ER/Outpatier			Nursing Ho	ome 5 Reside		(Specify)	
5	ding P	in oi	27. Manner of Death Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time o	f 280	lnjury at Work? 1 ☐ Yes 2	I No	28d. Describe ho	w injury occurred		
Jivisic	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director; After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of Injury - At ho ng, etc. (Specify	ome, farm, str				28f. Location (Str City or Town	eet and Number State)	or Rural Route Number,	-
	To the Hospitei or within 24 hours afte To the Funerei Dir completely filled in	edical Ce	29a. Certifier 1 Certifyin (Check only one) Medical I	Physician: To the	best of my kno isis of examina her stated.	wledge, deatl tion and/or in	h occurred at vestigation, in	the time, date my opinion,	and place, death occur	and due to the ca red at the time, da	use(s) and mann te and place, and	er as stated. If due to the cause(s)	
	o the ithin (o the omple	Mec	29b. Signature and title of certifier	/ and malk	Juneou.		29c. I	License numb	er	29	ld. Date signed (/	Month, Day, Year)	
	r s ⊢ ŏ		V/ TA	i Ta	basis		Г	46350	ì	A	pril 17,	,2006	
	3		30. Naire and a dress of person of KHOSROW TABA			OSLE	R DRI	VE TO)WSON		AND 218		
	Sta Regista		31. Date filed (Month, Day, Year)		egistrar's Signa	iture /	in it						

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death Month A Lay 200 5 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** CHARLES (T000) /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Northwest Hospital Center Baltimore If Under 1 Year If Under 24 Hrs. About 1 Days Hours Min. Month, Day, Year)

Months Days Hours Min. March 4,1924 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 212-20-9283 Director 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 13206 Maple Grove Ave. 21136 USA deeth 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced "naturei" WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 ie marked other than ' ury or other traumatic event, ins Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Goodyear Tire Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas W. Good Helen Marie Lawson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy V. Good Wife 13206 Maple Grove Ave., Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/29/06 Finksburg, MD Evergreen Mem. Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Time Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imms liate Cause (Final disease or condition resulting in death) **Physician** HEMORNHAGIC CEREBROVASCULAR a. MASSIVE /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit MELLITUS DIABETES Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 [Fetat death in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М efter death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide within 24 hours e To the Funersi C Hospitel 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 D41410 ER BANDALLS TOWN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEHTA HOSPITAL CENTE 2006 Registrar's Signature CENTER 211 33 MATHLUEST MO 31. Date filed (Month, Day, Year) MAY 0 2 2006 State Registrar

			1 - For State Registrar		State of N	/larylar		epartme Certifica			nd Mer		giene Reg. No.	06	137	Michigan de Michig
			1. Decedent's Name (First, M	iddle, Last)							2.	Date of De	ath		3. Time o	f Death
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	/Medi Examir		4a. Facility Name (If not institu		-				y, Town, or	r Location of E		P(1.		ounty of Death		
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2	Lat y failed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23a or 28a-f show sumatic event, the Medical Experimentment be notified at	Be			· -						_		14 W			
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<i>€</i> 0 0	that the ed by detac	a d	Part II. Other significant con	ditions contr	ributing to death	but not res	sulting in t	ne underlying	cause give	en in Part I.		23e. Did t	obacco use	contribute to t	he cause of	death?
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	X		Alucho	1 min	lm				02	330X	•		041	127/1	6	
	Q'		30. Name and address of per	son who corr	npleted cause o	death (Ite	m 23a) (T	/pe, Print)	0-	0		-	0/1	~ . / 0		_
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	•	For State Registrar	S	State of	Marylai	nd / Depa <i>Ce</i>			lealth : Death		ental H	ygien Reg. N	UU.	6	137	12
									2. Date of I		ay	Year	3. Time of	Death		
Physiciar /Medica		David Arthur Howe							apri		*	2006	0926	М		
Examine		4a. Facility Name (If not institution,	give stre	et and num	ber)		4b. City	, Town, o	r Location	of Death		4	c. County	of Death		
		Laurel Regional Ho	spita	1			Lau	rel				Р	rince	Geora	е	
neral			6. Sex		7. Age (In yrs	. last birthday)		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I				r Foreigi	
ctor		010 30 8310	1 (X) M	2 F	67	Yrs.	NOTIGIS	Days	Itours	IVIII.	09 24			MA		
		Usual Residence of Decedent														
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notified at	Director	MD Anne Ar	undel		Lau	rel									1 🙀 Yes	2 NO
9 5	E e	10e. Street and Number					10f. Zi	p Code				10g. Citizen of What C			ntry?	
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	Funeral	11. Marital Status			dent Ever in U	J.S. 13.			lispanic Or	rigin? (Spec	ofy Yes or fi	No-			an Indian,	
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16	<u> </u>	Raymond Howe, Sr. 19a. Informant's Name/Relationsh	in (Type	Print)		10h Maili	na Addres	e (Stroot	Control of the Parket Con-	Brown	Route Nur	her City	or Town	r Town, State, Zip Code)		
Å		Barbara Kay Howe,		, r rwity		8228 B	-							State, Zip	0000)	
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once.		4 Donation 5 Other (Specify) Columbia Memorial Park 05/04/2006 Columbia, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home														
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		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approxim												Approximat	Θ	
		shock, or heart failure. List only one cause on each line. tmmediate Cause (Final												Interval Between Onset and Death		
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13	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c		come of pregr		-						23d. Dat	e of delive	ery	
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á	2	Part II. Other significant condition	ns contri	buting to de	ath but not re	sulting in the r	inderlying	CAUSE OIV	en in Part	ı	23e. Die	d tobacco	use contr	ribute to th	ne cause of d	eath?
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	0	27. Manner of Death				28b. Time of		28c. Injur	v at		me 5 Residence 6 Other (Specify 28d, Describe how injury occurred			Y)		
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	Ē	4 Homicide determi	ben	buildir	of injury - At i	nome, tarm, st	reet, facto	гу, опісе		-	City or 1	own, Sta	te)	er or mura	ii Houte ivum	Der,
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7		William A. Warren,	mu 32	1	e Georg		ure	MD 20	1/0/							
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ORIGINAL

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Russell Lloyd Heath 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1237 hrs Russell Lloyd Heath **Medical Examiner** April 25, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital **Baltimore** N/A 5. Social Security Number If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** 6. Sex 7. Age (In vrs. last birthdav) Months Days Hours Min Director 21, 1931 Country) Ohio 1 X M 74 212-28-1342 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits Yes 2 X No , or items 23a or 28a-f show r must be notified at once. Anne Arundel Brooklyn MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examinor must be maifted or many. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21225 United States 825 Freeman Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married Yes White 1 Yes 2 X No specify: 3 Widowed 4 X Divorced If Yes, Give Year Specify ģ or Dates 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Automotive Mechanic 8 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Dernback Be Joseph Nicholas Heath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 107 Driftwood Court, Joppa, MD 21085 Karen Allen Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition timore, west Arundel Crematory Burial 2 X Cremation 3 Removal from State 4-28-2006 Odenton, MD Other Specify Donation 5 22 Name and Address of Facility Ambrose Funeral Home, Inc. 21 Signature of Funeral Service License 1328 SUlphur Spring Rd., Arbutus, MD 21227 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complications that caused the Physician failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, P. Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✔ Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes 2 No ဥ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined within 24 hours a To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) MD O.C.M.E. April 26, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

1

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of L			ene g. No.	13714		
	Physici		PARTOLL WASLAW Haddaway									
1	/Medio Examin	100	4a. Facility Name (If not institution, give 1467 Sykesville	street and number,		4b. City, Town, or Sykesvi	He	th	4c. County of	ward		
1	Funeral Director		21. 3. 02.0		ge (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9 1937	. Birthplace (State or Foreign Country) MD		
	e Maryland 3a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Howard	rille			10d. Inside City Limit					
21215-0036	3a or 2	I Dire	10e. Street and Number 1467 Sykesville R	10f. Zip Code 2 1 78	34	10	ng. Citizen of What USA	at Country?				
	n 72 hours after death with the Maryland "netural", or Itama 23e or 28e-f show salical Examinar must be molified at	eted by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad		160-164	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No Ident's Usual Occupa	Specify:	to Rican, etc.)		American Indian, White, etc. White mess/Industry		
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Maryland	should nd Men marke umatic	၉	Arthur Haddaway 19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street a		Meredith		ate, Zip Code)		
	and 2 ealth a m 27 is		Mrs. Rosalind Had	daway/w		and the second second	lle Rd.,	Sykesvil				
nore	m O		20a. Method of Disposition 1 → Gurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State) _	matory or other place wn Memoi	5/2	/06	20c. Location - Cit Ellicott	City, MD		
Baltimore,	permit. Page Department of Important: if any injury or		21 Single of Funeral Service Life Bryah W. Clary	1000	2	2. Name and Addres	s of Facility Vers Fur	neral Dire Randalls	ctors			
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O. Box 6	that the death certiticate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o	•		
<u>a</u>	The law requires that ite has been signed b page 2 should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause given in Part I. 1 Yes 2 No 3 Probably									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day	Year	3. Time of Death					
	/Medic	al	Robert Wayne Heis					April 2	7		2147 M		
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-	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth)	_	olace (State or Foreign otry)		
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a	permit. Pages 1 and 2 Department of Heelth a Importent: if Item 27 is eny injury or other trai		Mary W. Heiss/Daughter 8915 Bradmoor Drive, Bethesda, Maryland 20817 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State										
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	axl		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type,				F	- ,			
	47,		Anura S. Nathan, M		Rockvil	le Pike,	Suite 208	Rockv	ille, M	lary1a	and 20852		
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Pereaged by Medical Graminer

Robert

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State

Registrar

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2006

			For State Registrar	State of N	1arylan		artmen					giene ()	06	13717
	Division		1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	ath Day	Year	3. Time of Death
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	ίÔ		30. Name and address of person Joseph Kaplan, M					Pood	Poo	Jese # 7 1	1 o M =		2085	5
	Sta		31. Date filed (Month, Day, Year)		trar's Signa	ture		Road	, ROC	KVII.	le, Mar	yrand	2003.	J
	Registr	ar	MAY 0 2 200	A CASE	255	5 3								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Harrison, III 2006 9:20P William Ralph /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
5aint Joseph Medical Examiner Center Baltimore Towson 8. Date of Birth (Month, Day Year) 1957 Maryland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 M 2 □ F 212-52-0582 48 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ahow permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23a or 28a-f show any Injury or other traumatic event, the Mardical Exporter must be notified at once. 1 ☐ Yes 2 X No Baltimore Parkton Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 21120 2204 Mount Carmel Rd by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pauline Wolfe Harrison, Jr. Hazel Ralph W. ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Mount Carmel Rd., Parkton, MD 21120 Patricia A. Harrison-wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/29/06 Dulaney Valley Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fugeral Service License William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE 10 DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) METASTATIC COLON CANCER YEARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 100 3 ☐ Probably 4 ☐Unknown 1 🗌 Yes been sig Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performe s certificete has b lirector, page 2 st 2 No 1 Yes director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 / Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ٥ this After this funeral of 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Neturat 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D16587 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CHANG MD OSLER DRIVE, TOWSON, MARYLAND 21204 32 Registrar's Signat 31. Date filed (Month, Day, Year) State MAY 0 2006 Registrar

			1 = For State Registrar	State of M	arylan				ealth a	and Me		giene Reg. No.	106	3719
The same			1. Decedent's Name (First, Middle, Last)								2. Date of De. Month		Year	3. Time of Death
	Physici /Medic		Roger	F.	1	Hilemar)					24, 2		6:30 А.м
	Examin		4a. Facility Name (If not institution, give s)		4b. City,		Location of			4c. (County of Death	
or it		30°.		ERRACE			If I I and a		MINST				CARROL	
	Funeral Director		5. Social Security Number 6. Sex 297-26-3288	M 2□ F	73 ge (In yrs.	last birthday) Yrs.	If Under Months	Days	Hours Hours	Min.	8. Date of Bird (Month, Da 03-31-	h y, Year) -1033	9. Birth	place (State or Foreign htty) Ohio
	E .		Usual Residence of Decedent								00 01	1555		01110
	nyland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Ba-f	Director	MD. CARRO	LL.				MES	TMINS	IER				1 ☐ Yes 2/CXNo
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or llems 23a or 28a-f ehow thit, the Medical Examinational Le molfiled at	Dire	10e. Street and Number 927 WEDGEWOOD	TERRACE			10f. Zip	Code	2115	8		10g. Citiz	en of What Cou	·
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturet, or items 23a or 28a-f show entry or other traumatic event, the Medical Examinating the relified at ADRC.		19a. Informant's Name/Relationship (Type MARY ANN HILEMAN	(WIFE)		-						Town, State, Zij	O Code) AND,21158
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ШO	Pages lent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	MQ	ST HOL	Y RED	EEME	K O	4-28-	-2006	BAL	TIMORE,	MARYLAND
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F	Examin	er	4a. Fecility Name (If not institution, give stre	et and number)		WOODLA	Location of Death		4c. County of Dea	
	Funeral		3437 DAYTA DRIVE 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	h 9. Bir	thplace (State or Foreign
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	al', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	∏Yes 2∰ No	Specify:		Specify: B]	LACK
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2	be filed within 72 hours after deeth with the Maryland at Hygiene. A content of other than "natural", or items 23a or 28a-f ehow other than "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified.	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
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<u>a</u>	2 sho		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numbe	or, City or Town, State,	Zip Code)
ב ע	1 and Health am 27 ther t		CORA GORDON/SISTER 20a. Method of Disposition	20b. Pla	ace of Dispo:	sition (Name of		BALTIMOR Date	E, MD 2122	
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			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	721
	Physici			me of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and pumber) 4b. City, Town, or Location of Death 4c. County of Death A A	
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (S. Month, Day, Year) 9. Birthplace (S. Country) 1 Month, Day, Year) 9. Birthplace (S. Country) 1 Month, Day, Year) 9. Birthplace (S. Country) 1 Month, Day, Year) 1 Month, Day, Ye	State or Foreign
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	sath with	Funeral Director	106. Street and Number 1701 Eutaw Place 326 2/2/7 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	20
36	nit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland artment of Health and Mental Hyglene. ortent: If item 27 is marked other then "netural; or items 23a or 28a-f ehow injury or other treumatic event, the Madical Examiner must be notified at injury or other treumatic event, the Madical Examiner must be notified at a.e.	by	1 3 Not Wildowed 4 □ Divorced Specify:	<
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Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	Maas
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			1 - For State Registrar	State of	Marylar	-			lealth a Death		ental Hy	giene Reg. No	4 U U	6	13723
			Decedent's Name (First, Middle, L.)	ast)							2. Date of De	ath			3. Time of Death
	Physici		Lillian G. John	eton							April	30°	2006	Year	7:30P M
-	/Medic Examin		4a. Fecility Name (If not institution, ga		ber)		4b. City	, Town, or	Location of	of Death			. County of		
	LAGIIII	161	Suburban Hospit	a 1			Re	thes	da				Montg	omei	rv
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Bir	th		9 Bidhr	place (State or Foreign
	Director		002-18-7953	1 □ M 2 💢 F	8	30 Yrs.	Months	Days	Hours	Min.	(Month, Da Nov. 1	1, 1	925	New	Hampshire
	P		Usual Residence of Decedent		140.00	-				-					
	aryla	_	10a. State 10b. County		100. Ci	ty, Town or Lo	ocation								1 ☐ Yes 2 ☐ No
	98 A.	octo	Maryland Montgo	mery	Bet	hesda					-				
	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f ehow the Medical Exercia or must be motified at	Funeral Director	10e. Street and Number					p Code					itizen of Wh		,
	s 23s	ra	9508 Old Georget		took Consider to	10		0814	1	-:-0 (0	-4. V 1		ted S		
	er de	nue	11. Marital Status	12. Was Deced	ces?	1.5.	If Yes, spe	ecity Cuba	in, Mexican	n, Puerto l	cify Yes or No Rican, etc.)	-		White,	
36	rs af	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give Year or Da	•		1 ☐ Yes	2 💢 No	Specify:				Specify:	LTh -	ite
Ş	tura atura	ed	15. Decedent's			16a. Dece	dent's Usi	al Occup	ation			16b. F	Cind of Bus		
75	n n n	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-	Ans S. \	(Give	kind of w DO NOT i	ork done d use retired	during mos f)	t of workir	ng				•
2	r the	E	12	College (1	401 54)	Secr	etary	/Hom	emake	r		N.	I.H./	Own	Home
ਲੂ	othe	Be C	17. Father's Name (First, Middle, Las	st)					18. Mothe	er's Name	(First, Middle,	Maide	n Sumame,)	
<u>a</u>	Aenta Aenta rked tic e	To B	Daniel Gilmore						Emi	.1y D	ube				
ary	should have		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street	and Numbe	er or Rura	Route Numb	er, City	or Town, S	tate, Zip	Code)
Σ	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Menial Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show spiritury or other traumatic event, the Mudical Examinat must be multified at ODGs.		John T. Johnston	/Husband		9508	01d	Geor	getow	m Ro	ad, Bet	hes	da, M	ary.	land 20814
Baltimore, Maryland 21215-0036	of He		20a. Method of Disposition	□D16 0		Place of Disponentery, crea	osition (Na matory or	me of other plac	(a)	D	ate	20c. L	ocation - C	ity or To	own, State
Ĕ	Pege nent in int: if		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec			ne Grove	Cem	eter	y 1	May 8	3, 2006	Sa	lem,	New	Hampshire
ati	Depentit. Depenting imports any inju		21. Signature of Funeral Service Inc	ensee		2:	2. Name a	nd Addre	ss of Facilit	y Rob	ert A.	Pum	phrev	Fui	neral Home
m	8858		Wist	Lug	- MO	0803 B	ethes ethes	da-C	hevy Marvl	Chas	e, Inc. 20814-	. /5 -350	5/ Wi 1	SCO	nsin Avenue
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca	used the deat										Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ticemi	а									Onset and Death Days
	/Medical		resulting in death)	a	or as a consec										o Day B
ı	Examiner		Sequentially list conditions	b											
7	D =	Examiner	Sequentially list conditions, if my leading I immediate cause. Enter Underlying	Due to (c	or as a consec	quence of):									
V	ecute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c										_	
Ö,	e exe ien a urial-	ŭ	resulting in death) Last	Due to (or as a consec	quence of):									
8760,	requires that the death certificate be executed been signed by the ettending physicien and hould be detached for use as the burial-transit	dical	•	d										-	
9	eath certific ettending p I for use as	Mec	IF FEMALE:	00- 11		22									
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?		rth 2 Feta	al death 3	Ectopic p		,				23d. Date Mont		ery Day Year
_ _	the e	/sic	1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	4∐Pregna 9□ Unkno	int at time of o wn	death 5L	Other (s	респу)							ŕ
P.O.	that the de ed by the detached	by Physician/Me	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying	cause div	en in Part I		23e. Did t	obacco	use contrib	oute to t	he cause of death?
Division of Vital Records,	w requires that been signed I should be det	δ	Non-Small Cell									Yes 2			pably 4 □Unknown
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Sec.	The law ste has b page 2 si	Completed					-				24a. Was		24b. W	ere auto or to co ath?	psy findings available mpletion of cause of
듄	: Th										1□ Yes		0 10	Yes	2□ No
Ž	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				OA Oth	ar		Check only o				
of	Phys this aldir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ∑ Ir 28a. Date o		28b. Time o		UA	4 □ Nu		ne 5 Resi				ý)
UC.	ling l	lo	1 Natural 5 ☐ Pending	(Mont)	Day Year)	Injury	" м	28c. Injur Wor	vat k? Yes 2□		od. Describe	now inju	ary occurred	u	
isic	Attending ir death. ector: After by the fune	cat	2 Accident investigate 3 Suicide 6 Could not	be 300 Bloom	of Injury - At h	ome farm et			185 2		PRf Location /	Street a	nd Number	or Bur	al Route Number,
<u>></u>	or A after Direction by	Certification:	4 Homicide determine	d buildin	g, etc. (Speci	fy)	reet, racto	ry, othou			City or To			Or Mura	i ricale Namber,
_	Hospital		29a. Certifier 1 Certifying I	Physician: To the	best of my kor	owledge dest	h occurre	d at the tim	ne date an	nd place a	and due to the	Cause/	s) and man	ner as a	tated
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Ex	aminer: On the ba	sis of examina	ation and/or in	vestigatio	n, in my o	pinion, dea	ith occurre	ed at the time,	date an	d place, ar	nd due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		10		29	c. Licens	e number			29d. Da	ate signed	(Month,	Day, Year)
)	- S - O		> Michael a	1. Wes	termas	n, M.	١.	D52	/ ₁ 5 1			Mar	. 1 2	006	
	16		30. Name and address of person wh			(Ност	itol	riay	1, 2	000	
	15		Michael A. Weste						rban wn Ro		itai Betheso	la.	Marv1	and	20814
	Sta	ite	31. Date filed (Month, Day, Year)		gistrar's Sign	79	de	0							
	Registr			OC AVE.	100 a 100	1									

DHMH 17 Rev 1/2001

Johnston, Lillian 4/30/06 7:30 PM

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 2 2006

2. Registrar's Signature

Please Type or Print in Black Indelible Ink William George Kunkel State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** 1036 hrs William April 27, 2006 George Kunkel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 805 McKim St. Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 9 Birthplace (State or **Funeral** Foreign Months Director $_{1}X_{M}$ Days Hours 218-40-0653 65 Country) 10/18/1940 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 X Yes 2 No Baltimore N/A 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 805 McKin Street 21202 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black or items Armed Forces 1 X Never Married 2 Married White, etc 2 X No Yes Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Year marked other than "natural", c event, the Medical Examiner Specify: white à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Itimore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hor trinent of Health and Mental Hygiene trant: If item 27 is marked other them in the page of the parked other them in the page of during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1 Custodian Apartment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be or other traumatic event, William Kunkel Mary Schissler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Kunkel - brother 133 Radio Circle, Middle River, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Important: 1 Chesapeake Crematory 4/29/06 Beltsville, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee A. Stephen D. Lohrmann, Green Pastures Drive; M00986 Towson, 21286 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and ca UNPENDED AMENDED attending physician for use as the burial Physician/Medi Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ð 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 🗸 Yes 2 [No director, Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes ٩ 2 No 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject shot self Natura FOUND Pending Yes 2 🗸 No Funeral Director: stely filled in by the Apr 27, 2006 1030 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 805 McKim Street, Baltimore, Md. determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 1 within 2 To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 28, 2006 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

MAY

egistrar's Signature

06-02902 Elizabeth Klein

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Certifica	ate of De	ath		,,,	Reg No.	2006	13726
Physicia		Decedent's Name (First, Middle,La	st)					Date of De Month	Day	Year	3. Time of Death 0339 hrs
Medical Exami	ner	ELIZABETH 4a. Facility Name (if not institution, g	KLEIN		I dh. Cit	, Town, or I	Location of	April 30,	2006	County of Death	
,		John Hopkins Hospital	ve street and number)			timore	LUCALIUN UI	Deall	40. 0	N/A	
Funeral		5. Social Security Number 6. 3	Sex 7 Age (In yrs. last birth	nday) If U	nder 1 Year	If Under	24Hrs. 8. Date of E	irth (MM/DE	D/YYYY) 9. Birt	hplace (State or
Director		220-51-1422	M 2XF	8	Yrs. Mo	nths Days	Hours	Min. 4/24/	1998	Foreign Cou	n MARYLAND
	ŀ	Usual Residence of Decedent						17~17	1770		
, any		10a. State 10b. County		Oc. City, Town		-					10d. Inside City Limits
Maryland 28a-f show d at once.	5	MD BALTIN	IORE	PAR	KVILLE						1 Yes 2 XNo
Maryl 28a-t d at o	Director	10e. Street and Number			10f.	Zip Code			10g. Citize	n of What Coun	ntry?
th the Maryland 23a or 28a-f sho notified at once.		2907 LINGANORE A	VENUE			21234			U.	SA	
th with the n	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Ev Armed Forces?	er in U.S.				n? (Specify Yes or No Puerto Rican, etc.)	lo- 14	 Race - Americ White, etc. 	can Indian, Black,
er dear	Ē		1 Yes 2 X	No						T 77.7	T/07
5-0036 led within 72 hours after death with the Maryland tygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	ē	Widowed 4 Divorce Divorce Specify	or Dates:	eted) 16a. [1 Yes			nd of work done		d of Business/Ir	ITE ndustry
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036 thin 7	ď	2ND GRADE			N/A				N	/A	
		17. Father's Name (First, Middle, Las	t)	•		1	18. M other's	Name (First, Middle	Maiden Su	ırname)	
T 4 - 2 - 1	a	KEVIN KLEIN						RICIA POO			
more, MD 2121 Pages I and 2 should be fi pent of Health and Mental I ant: If item 27 is marked or other traumatic event,	ပို	19a. Informant's Name/Relationship KEVIN KLEIN/FATH						er or Rural Route N			
e, MD and 2 shc Health and item 27 is		20a. Method of Disposition	<u>er</u>		f Disposition (E BALTIM Date		cation - City or	
Ore ges I tof H tof H it		1 X Burial 2 Cremation 3		cremato	ory or other pla Y VALLE	ce)	· ·	5/4/2006		ONIUM,	
나 를 을 다 크.	- 1	4 Donation 5 Other Special 21. Signal re of Funeral Service Lice	y: ,	CAPDEN	~			THE JOHNS			
Balt permit Depart Impor injury		21. Signature of Purietal Service Lice	House					BLVD. T			OME, P.A. 1286
Physician		23a. Part I. Enter the disease, or con	iplications hat caused th	e death. Do no							Approximate Interval
/Medical		failure. List only one cause on Immediate Cause (Final disease	each line." a. Multiple Injuries w	ith complic	ations						Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a consequ								-
Marie Contraction of the Contrac	_	Sequentially list conditions,)								
	Examiner	if any, leading to immediate	Due to (or as a consequence	uence of):							
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and and trans			d								
D, be ex sician	sician/Medical	UNPENDED	AMENDED								
3760, ficate be g physici s the buri	M/C	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth		Fetal dea	th 3 [Ectopic	oregnancy		Date of delivery Ionth D) Day Year
Box 687 e death certifine the attending ed for use as t	icial	past 12 months?	4 Pregnant at tir				Lotopio	prograticy	"	ionar D	ray roan
BO:	Phys	1 Yes 2 V No 9 Unknow	9 Unknown								
bat the	by P	Part II. Other significant conditions	contributing to death b	out not resulting	g in the underly	ing cause g	iven in Par	1 —	_		the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the saft of earth. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed b	-									ably 4 Unknown
ord w req as bee	Completed								opsy	prior to c	topsy findings available ompletion of cause of
Rec The la	E O								formed?	death? 1 ✓ Ye	s 2 No
tal Rectian: The certificate ector, page	Be C	25. Was case referred to medical examiner?						Check only one)			
hysic this of all dire	ToE	1 🗸 Yes 2 No	Hospital: 1 Inpatient		utpatient 3		-	Nursing Home 5	Residenc		·
n of ding Ph	.: ::	27. Manner of Death 1 Natural 5 Roading	28a. Date of Injury (Month, Day Yea Apr 21, 2006	r) 28b. 1	Time of Injury) hrs		ry at Work?	Passenge		occurred Nolved in co	oilision
Sior Attend death cctor:	catio	2 ✓ Accident 5 Pending Investiga	ation	33-			′es 2 ✓ I		(0)		E-10
Jivis	Certification:	3 Suicide 6 Could no determin			irm, street, tact	ory, oπice b	ullaing, etc	or Town	State)		ral Route Number, City
Opital ospital hours a uneral I		4 Homicide	(Opacing) Loca		ath applicand of	the time de	to and also	2842 Cub			
Division of Vital Records, P.O. Box 68760, Vital Records, P.O. Box 68760, Vittin 10 the Hospital or Additional Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contract of t	Medical	(Check only Certifying Phys	cian: To the best of my ler: On the basis of examination								
To the within To the comple	Med	29b. Signature and title of certifier	and manner stated			29c. Licens				ate signed (Mor	
		aws	<			O.C.	M.E.		May 1	1, 2006	
1		30 Name and address of person wh	completed cause of dea	ath (Item 23a)							
2			ant Medical Examir		Penn Stree	, Baltimo	re, MD 2	21201			
S	tate	31 Date filed (Month, Day, Year)	32 Registrar's	Signature	1 2						
Regis	trar	MAY 0 2 20	16 Regues	N.	(parte						

			1 - For Stata Registrar			rtificate of D		lental Hygi	g. No.	13161
	* L	Į.	Decedent's Name (First, Middle, L.	ast)				2. Date of Death		3. Time of Death
	Physici /Medic		Carolya	kinser				April 2	26 200	62:32 pm
j	Examir		4a. Facility Name (If not institution, g	. / / .	111	4b. City, Town, or		"M M	4c. County of Dea	
					(In yrs. last birthday)	If Under 1 Year	Il Under 24 Hrs.	8. Date of Birth	Baltin	thplace (State or Foreign
ľ	Funeral Director		219-30-4834	1□M 2 ⊠ F 73		Months Days	Hours Min.	Jan. 30	Year) C	ountry)
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	Maryli f sho	tor	Maryland N/A		Baltimore					1X∑Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	1	Daitimore	10f. Zip Code		10	g. Citizen of What C	ountry?
	th with		242 Medwick Gart	h East		21228			USA	
	ema ema	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	rer in U.S. 13.	Was Decedent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	d within 72 hours after death with the Maryland jone. r than "natural", or itema 23a or 28a-f show the Madical Examinar must be notitled at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 😿 No If Yes, Give Year or Dates:		1 ☐ Yes 2]② No			Specify:	White
21215-0036	2 hou	ted l	15. Decedent's	Education	16a. Dece	dent's Usual Occupa	tion	1	6b. Kind of Business	Vindustry
218	thin 7 e	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done de DO NOT use retired)	urin g most of work	ing		
2	TO TO SERVE		12		Но	memaker			Own Hor	ne
and	A la b	Be	17. Father's Name (First, Middle, Late George	Daniel	7	lehmeyer	18. Mother's Nam Marie	e (First, Middle, Mi	aiden Sumame) Rosalie	Saffran
Maryland	should ind Men ind Men in marke	ဥ	19a. Informant's Name/Relationship			ng Address (Street a				
S	s 1 and 2 should I Health and Men Item 27 Is marke other traumatic		James C. Kinser,	Jr. (Son)		Green Va				
Jre,	es 1 a of Height filtern ir other		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)	Date 2	0c. Location - City or	Town, State
Ē	nit. Pages lartment of I ortant: If its injury or o		1 ☐ ₂ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Meadowrid	lge Memori	al Park			•
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic	ensee		2. Name and Address				
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			shock, or heart failure. List on	ly one cause on each line.					st,	Approximate interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a. Juba	consequence of):	is he	morrh	erge		
	Examiner			Due to (or as a t	consequence or);					
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of).					
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68760,	tificate be executed g physician and as the burial-transit	edical		, d.						
Box (n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	livery
Ď	death le atte	Physician/M	in the past 12 months? 1 Yes 2 No	1 Live birth 2 4 Pregnant at tir	_	∃Ectopic pregnancy ∃ Other (specify)			Month	Day Year
	at the	Phys	9 Unknown	9□ Unknown						
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ds, P.O.		_		out the death out the	not resulting in the d	nderlying cause giver	n in Part I.			the cause of death?
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 6:00 pm 4a. Facility Name (If not institution, give street and number) Katkish April 24 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | November 25 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year 1 M 2 K F 83 1922 Pennsylvania 578 32 7392 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 No Director Maryland Prince George 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14011 Briarwood Drive 20708 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: Ď 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Housewife. Own Home permit. Pages 1 end 2 should be file Department of Heatih and Mental Hy, Important: if item 27 is marked othe any injury or other treumetic event, 20028. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Curto Anna Centanino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Katkish, DAughter 601 Pennsylvania Ave. NW Ste. 900 South, WAshington, D.C. 20004 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Edgewood Cemetery 04/28/2006 Saltsburg, Pennsylvania Fleck Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7601 Sandy Spring Road, Laurel, MD 20707 upmovell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial Hemorrhage /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physicien at s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been sig 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MacUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?
Yes 2 No After this certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of pertified D0063653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) though County General Hospital 5755 Codor Lane Columbia, Maryland 21044 Shawn Evans

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

		1 - For State Registrar	State of Marylan		nt of Health and te of Death	Re	4 UUU	13729
Physici /Medio Examin	al	Decedent's Name (First, Middle, Last A Th Aa. Facility Name (If not institution, give S TELLA MARIS	Street and number)	4b. Ci	y, Town, or Location of Dea		Day Year 2000 4c. County of Death BALTIME	ORE
Funeral Director		5. Social Security Number 6. Se 209-09-0979 Usual Residence of Decedent	7. Age (In yrs.	/ Ast birthday) If Unc Yrs. Month	ler 1 Year If Under 24 Hr s Days Hours Mir		Year) 9. Birth 1916 PEHN	nplace (State or Foreign untry) SYLVANIA
IL Z IZ IS-UUSO filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23a or 28s-f ehow int, the Medical Examinant mention at	Director	10a. State 10b. County MARYLAND		ty, Town or Location ACTIMORE				10d. Inside City Limits 1 ☑ Yes 2 □ No
ING Z IZ IS-UUSO be filed within 72 hours after death with the Marylan ital Hyglene. id other than "natural; or Iteme 23s or 28s-f ehow avent, Ira Medical Exaction must be netitied at	Funerai Dir	10e. Sfreet and Number 4509 ARABIA 11. Marital Status	AVE. 12. Was Decedent Ever in U Armed Forces?		Tip Code Z/Z/4 sedent of Hispanic Origin? (secrify Cuban, Mexican, Pue		Og. Citizen of What Con	ican Indian,
72 hours after natural, or its	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: W	HITE
od within 72 giene. er then "nei	Completed	(Specify only highest grad		life. DO NOT	vork done durina most of w	orking	16b. Kind of Business/I	ndustry
ed la be	To Be (RIVOSH	10h Maillea Adda	MAK	ame (First, Middle, N	6	
ges 1 an t of Heal ff Item 2 or other		19a. Informant's Name/Relationship (T) 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	SON 20b. F	Place of Disposition (A completery, crematory of the completery)	ss (Street and Number or Fifth BLUM, ame of other place) If RY MAY	ATTA BAL	City or Town, State, 2. THORE MAR. Oc. Location - City or M. ALTHORE	MAND 21234
permit. Par Departmen Important: any Injury		21. Signature of Funeral Service Licens Muchael Ma	apello	6009	and Address of Facility / y	BALTIMO	NERAL CHAPE	AND 21214
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. BRAIN CANCER Due to (or as a conseq		ode or dying, such as cardia	ac or respiratory arre	St,	Approximate Interval Between Onset and Death
ate be executed systicien end he burial-transit	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq c. Due to (or as a conseq d					
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Il déath 3 □Ectopic			23d. Date of deliver Month	very Day Year
2 2 2 2	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.		acco use contribute to	the cause of death?
II necolus, The law requires to sale has been signed page 2 should be considered.	Completed					24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of 2 No
vician: T	Be	25. Was case referred to medical examiner?	Hospital:		7.04	eath Check only one	P	
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LIVISION tal or Attending rs after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory)	ory, office	28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
To the Hospital within 24 hours a Completely filled	Medicai	(Check only 2 Medical Exami	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To t com	Σ	29b. Signature and title of certifier	N.	2	9c. License number D4372		d. Date signed (Month)	
10		30. Name and address of person who co	2300 DULANE	Y VALLEY R	D. TIMONIUM	, MD 21093	1	
Sta Registr		31. Date filed (Menth Cay, Year) 20	Registrar's Signa	ture de la constant				

APRIL 29, 2006 9:30 p.m.

CATHERINE KLUGE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Elizabeth 3:10 PM Margaret Ketterle 4 28 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 343 Tulip Oak Ct. Anne Arundel Linthicum If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-15-1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 234-70-3087 1 □ M 2 17 F 63 WV Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Neulcal Examinar must be multilad at MD Anne Arundel 1 ☐ Yes 2 🔯 No Linthicum Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 343 Tulip Oak Ct. 21090 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If Itam 27 Is marked other than *natural', or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Durkin Emma Tibbins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Morris Ketterle/husband 343 Tulip Oak Ct., Linthicum MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It sny injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/5/06 MD Veterans Cemetery Crownsville 4 Donation 5 Other (Specify) William Litense 22. Name and Address of Facility 21. Signatu Singleton Funeral Home 1 Second Ave SW Glen Burnie MD 21061 MOHAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death) Immediate Cause (Final **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ģ in the past 2 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) detached 9□ Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? has page 2 certificate To the Hospital or Attanding Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 X Hesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name) and address of person who completed cause of death (Item 23a) (Type, Print) 00 1162 30 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

			1 - For State Registrar	State of	Marylar			nt of H		ınd M	ental Hyg	iene	Õ	13731
雷	Physici	an	1. Decedent's Name (First, Middle, I		V.	77	-				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio	al	4a. Facility Name (If not institution, g	Betty		Kelly		Tours or	Location of	f Death	April	25,2006		9:50 P M
ı	Examir	ier	96 Delmar Avenu		2017		40. City		undal			,		more
*	Funeral			Sex 7	. Age (In yrs.	last birthday)	If Unde Months	r 1 Year	If Under 2 Hours		8. Date of Birth (Month, Day			place (State or Foreign htry)
	Director		216-20-3163	1□M 2\\ F	83	Yrs.	Wolful S	Dayo	1100,0		Sept. 1			yland
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary B-f eh	tor	Maryland B	altimore			Dund	alk						1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number				10f. Zi	Code			1	0g. Citizen of W	hat Cour	ntry?
	e 23a	rai	96 Delmar Ave.	40 11/40 12-4-1	4-1-E	10	11	(T.) (I.E.	2122		-7. 2	United		can Indian,
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Division	Dir	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ZOB. FIACE	of Injury - At h g, etc. (Speci	iome, farm, str fy)	eet, factor	y, office		2	28f. Location (Si City or Town	treet and Numbe n, State)	r or Rura	al Route Number,
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	Ц		30. Name and address of person with	o completed cause	of death (Ite	m 23a) (Type,	Print)	1.	0.1	1	2007	neb.	. /11	6 EMDZOF
	Sta		31. Date filed (Month, Day, Year)	SOUS L	gistrar's Sign	4 XC	TTA	ClAn	1 12(1	12	we C	Kleys	411	CMD402
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** April 25, Mary Ρ. Kerr 2006 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6309 Orchid Drive Montgomery Bethesda 8. Date of Birth (Month, Day, Year)
July 3, 1916 If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□ M 2X F 296-09-1986 Director 89 Yrs. Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itema 23a or 28a-f ahow the Modical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6309 Orchid Drive United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ል 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: if item 27 ia marked other the eny injury or other traumatic event, IIIs once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be John Jingo Anna Saumel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean V. Uebele / Sister 6309 Orchid Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. ngelettel annis M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Years Dementia /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit Cerebrovascular Disease Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Pressure (Decubitus) Ulcers, Hypothyroid 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate hes b irector, page 2 sl autopsy performed? 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 X Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D50030 April 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue, Suite 1400, Chevy Chase, Maryland 20815 David Rogers, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			For State		Marylan	d / Depa		of Hea	alth a		•	ygiene	006	137	33
-30	-2 6		Registrar Decedent's Name (First, Middle,	Last)			imouto	0, 00	Jul 17	1:	2. Date of D	Reg. No.		3. Time o	f Death
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9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show its Medical Examiner must be notified at	ed b		15. Decedent's Edu	Year or Dates:			dent's Usual (101	Specify: Wh:		
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DILIA	11147.0: 4/04	0.4			- COLAR	Tab -	The state of the s	S. A. C.							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 45 AM LOGUE TOMAS 35 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A E)SC) MOSPINAL BARTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. XXM 2 F Director 218-14-7588 81 Yrs. 1925 Jan. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at X Yes 2 No Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3939 Roland Avenue Apt. 612 "natural", or Itams 23a 21211 USA death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or iten any injury or other traumatic event, its Madical Examinations. Black, White, etc XXYes 2 ☐ No If Yes, Give Year or Dates: 1x Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: ģ white 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sewage Treatment City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joshua Raymond Logue Maria Anna Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell Harris 4111 Falls Road Nephew Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran Cem. 5/3/06 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest, MD 22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 21. Signature of Juneral Service Micenses Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat Immediate Cause (Final disease or condition resulting in death) MEN ORNHAME - TRACRALIAC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examine attending physicien and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Thin lahow 1 Yes 2 No 3 Probably 4 Whiknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Tes 210 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 🗸 0 2 Impatient 2 ER/Outpatient 3□ DOA After the 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No the hours after deat 3 ☐ Suicide 6 Could not be within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) APRIL 28 2006 D42434 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL PLACE BACTIONSE, 10 OSEPH 301 ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature Const. State MAY 0 2 2006 Registrar

			1 - For State Registrar	State of M	arylan		artmen <i>tificat</i>			nd Me	, ,	iene g. No.	96	13736
	Physici /Medi		1. Decedent's Name (First, Middle, La	st)				LAN	6	2.	Date of Death	Day 26	Year 2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, given the second of	107K:05		1:40/ last birthday)	4b. City, If Under Months	Him	OLE If Under 24 Hours	Hrs. 8.	Date of Birth (Month, Day,	Year)	/A	place (State or Foreign
	Director		216-32-1386 Usual Residence of Decedent 10a. State 10b. County	Q M 2 0 F	71	Yrs.					ec. 3,	1934	Mar	ryland Od. Inside City Limits
	the Maryli 28a-f eho	Director	Maryland F	Baltimore			10f. Zip	Code	I	Dunda		ng. Citizen of N		1 ☐ Yes ŽIŽ No
	hours after death with the Maryland turel', or tteme 23e or 28e-f ehow at Examiner must be nutified at	Funeral Di	3433 Dunran Roa	12. Was Decedent Armed Forces?		S. 13. V		2122		? (Specif	y Yes or No- an, etc.)	Unite	d Sta	ites can Indian,
-0036	bours after turel; or it	þ	1 ⊠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	1 √ Yes 2 ☐ If Yes, Give Year or Dates:	^{N₀} 1957		I □ Yes	2 ∑ No	Specify:			Specify 6b. Kind of Bi	y: W	Thite
21215-0036	d within 72 giene. or than "na!	Completed	(Specify only highest grant Elementary/Secondary (0-12) 9 Years	de completed) College (1-4or :	5+)	(Give life. L	kind of wo DO NOT us	rk done d se retired,	uring most of					uring
and	ould be filed Mental Hygi arked other attic event, I	To Be (17. Father's Name (First, Middle, Last George Lang						18. Mother's Mary		irst, Middle, M	faiden Suman	ne) ukr	1.
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Mr. Leroy E. Spo		r.		West	Spri			oute Number. Ct. Ed	gewood	, MD	21040
Baltimore,	Page sent o nt: if ry or		1⊠ Burial 2 □ Cremation 3 □ 4 □ Dopation 5 □ Other (Special 21. Signature of Fig. and Septice Local	y)	CE	emetery, cren LLY Hi	natory or o 11 M€	ther place	dns.	4/28/	2006		e Riv	ver, MD
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-	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CALS AC. Due to (or as	a consequ	Schen	niA			,	/		2	Interval Between Onset and Death hours
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Box 6	death certific e ettending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal	death 3	Ectopic pr Other (sp						te of delive	ery Day Year
	law requires that the as been signed by th 2 should be detache	6	Part II. Other significant conditions of Severe Aor +			ulting in the ur	nderlying ca	ause give	n in Part I.			acco use cont s 2 \(\sum \text{No} \)	ribute to th	ne cause of death?
œ .	The law resete has be page 2 sho	Completed					-			-	24a. Was an autopsy perform	ed?	prior to cor death?	psy findings available mpletion of cause of
r Vita	Physician: Th this certificete rai director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 700	Hospital:	ont 2 🗆 8	ER/Outpatien	3 DO	A Othe	-		heck only one		er (Specifi	v)
o uois	Attending Phr c death. ector: After th by the funeral		27. Manner of Death 1 Actural 5 Pending 2 Accident investigation		ry y Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y			. Describe how			<u>//</u>
DIVI	a 를 등 등	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, et	c. (Specify	")					City or Town,	State)		l Route Number,
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	4+1		30. Name and address of person who Rajesh Gupta M		eath (Item	23a) (Type, I	Print)	St	B41	Himi	13. MA	rey lan	d 2	2006
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g ga 7	(t)		1. Decedent's Name (First, Middle	, Last)	·						2	. Date of De.				of Death
	siciar edica		Elvira A. Lope:	3							A	pril			2:	00P M
	mine		la. Facility Name (If not institution	, give st	reet and n	umber)				Location of			4c.	County of De	ath	
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th with t	10	B .	10e. Street and Number 205 Shadow Glen	Cou	ırt				p Code 20878				-	izen of What (ited S	-	
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lore, Maryla ges 1 and 2 should t of Health and Mer if Item 27 is marke	i i	2	19a. Informant's Name/Relations	hip (Typ	e, Print)		19b. Mailir	na Addres	s (Street a					r Town, State	Zip Code)	
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altimore, rmit. Pages 1 ar partment of Hea portant: If Item		1	20a. Method of Disposition				. Place of Dispo	sition (Na	me of other place	φ) Δ	pril	26	20c. Lo	ocation - City o	or Town, State	
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			1 7.1	6	19	13	mo		D227	75 MD			Apri	il 25,	2006	
15)	- 1	30. Name and address of person Frederick G. Ba		M.D.	5454	Wiscons	in A	venue	, #13	00, 0	Chevy (Chas	e, Mar	yland 2	20815
Reg	State gistra	1	31. Date filed (Month, Day, Year) MAY 0 2	2006	32.	Registrar's Si	nature (1)									

			1 - For State Registrar	State of Ma			artment of H tificate of L		-	giene Reg. No.	106	13738
	DI		1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Patric	ia Ann Roys	ster Loz	upo	ne		April	28,	2006	6:24 P ^M
	Examir		4a. Facility Name (If not institution, g.	ve street and number)			4b. City, Town, or	Location of Death		4c. Co	unty of Death	1
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	Funeral			Sex 7. Ag 1 ☐ M 2 🖾 F	e (In yrs. last biri	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	Col	place (State or Foreign untry)
	Director		228-24-2407 Usual Residence of Decedent		87	113.			December	15, 19.	18 Vir	ginia
	land w		10a. State 10b. County		10c. City, Town	or Lo	cation					10d. Inside City Limits
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	r 288	rec	10e. Street and Number				10f. Zip Code	-		10g. Citizen	of What Cou	untry?
	h with	0	7903 Greentree	Raod				20814		Unit	ed Sta	ates
	deati	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No		Race - Amer	ican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23e or 28e-f ehow any injury or other traumatic event. I're Medical Exerting russi be notilized at Ance.	by Funeral Director	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	No	1	fYes, specify Cuba I□Yes 2∏ No	Specify:	rican, etc.)	Sp	Black, White ecify: W	hite
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Jai	12 sh h and 7 is n		19a. Informant's Name/Relationship	, , ,			g Address (Street a					
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ŏ	in it it		1 ☐ Burial 2 X Cremation 3	Removal from State	cemeter	y, cren	natory`or other plac	⁹⁾ May	1,		•	
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			23a. Part1. Efter the disease, or con shock, or heart failure. List onl	mplications that caused y one cause on each li	the death. Do r ne.	ot ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	50701 55 10	Approximate Interval Between
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_	death certific attending p	-	IF FEMALE:	23c. If yes, outcome	of pregnancy					224	Date of data	
å	The law requires thet the death certif tte has been signed by the attending page 2 should be detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy Other (specify)			230.	. Date of delive Month	very Day Year
Division of Vital Records, P.O. Box	y the	iys	1 ☐ Yes 2 █️No 9 ☐ Unknown	9□ Unknown			(4,000)					
σ.	thet led b	y P	Part II. Other significant conditions	contributing to death b	ut not resulting in	the ur	nderlying cause give	n in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
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á	al or afte i Dire	Certification:	4 Homicide	building, et	c. (Specity)				City or To	wn, State)		
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7	20		30. Name and address of person with	1	nath /ltom COst	Type				-1/	1	
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Patria Lozupowe

		State of Ma 1- State Amend ITem #5 Per F	ryland / Depa H G855 9 2				ene	13739
Dhysisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Yea	3. Time of Death
Physici /Medi		Bessie Anna Driver Legg				April .		1:25P M
Examir	ier	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of De	eath
		9704 Inaugural Way 5. Societ Security Number 6. Sex 7. Age	(In yrs. last birthday)	Montgom If Under 1 Year	ery Villa If Under 24 Hrs.	ge 8. Date of Birth	Montgom	Sirtholace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 XF	93 Yrs.	Months Days	Hours Min.	(Month, Day, Dec. 12	Year)	Country) Virginia
1.00		Usual Residence of Decedent						10d. Inside City Limits
arylar show	5	10a. State 10b. County	10c. City, Town or Lo					1√2 Yes 2 □ No
the M	Directo	Maryland Montgomery 10e. Street and Number	Montgome	ry Villag	ge	10	g. Citizen of What	21
with with	ם	9704 Inaugural Way		20886			United S	
death ms 23	era	11 Marital Status 12 Was Decedent 8	ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto I	ocify Yes or No-	14. Race - A Black, W	merican Indian,
urs after	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 N 1 Yes, Give 3 Widowed 4 Divorced 1 Yes or Dates:	lo	1 ☐ Yes 2X No		Alcan, etc.,	Specify:	White
72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of workii	na	16b. Kind of Busine	ss/Industry
ithin 7	nple	Elementary/Secondary (0-12) College (1-4or 5	life.	DO NOT use retired	1)			
led w tygier her th	ဝိ	17. Father's Name (First, Middle, Last)		Teacher	18. Mother's Name	(First Middle A	Public :	School
id be fi ental H ked ot ic ever	To Be	Casper M. Driver			Mabel La		aldon Gamaino,	
shou and M s mar	Γ.	19a. Informant's Name/Relationship (Type, Print)			and Number or Rura			
and 2 salth and 27 is		John D. Legg / Son			, Bethany			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show appringury or other traumatic event, the Medical Exercit or must be notified at once.		20a. Method of Disposition 1 ÄBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposementery, cre Barren R of the Bret	matory or other place	ch Apri	1 20, $ A $	oc. Location - City ugusta ounty, Vi	
permit. Departming supports any inju		21. Signa urb of Funera Sovice Licensee MO	R	2 Name and Addresobert A. Pu		ral Home/I Bethesda,	Bethesda-Ch Maryland 2	evy Chase, Inc 20814
\$1 8 \$20		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final	10.		ng, such as cardiac c	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition a. Alzh	eimer's De	ementia				Years
Examiner		Fail	ure to Thi	rive				Days
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
icate be executed physician and s the burial-transit	Examiner	that initiated events C.	a consequence of);					
ate be exchysician at the burial		Due to (or as	a consequence or,					-a-e-e
0 0 0	gglc	d						
death cer e attendir id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of Month	delivery Day Year
hat th od by detach		Part II. Other significent conditions contributing to death b	ut not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	pacco use contribut	e to the cause of death?
signed I	d by			, ,		1 □ Ye	s 2 🔀 No 3 🗆	Probably 4 Unknown
he law requires that the e has been signed by the age 2 should be detached.	Completed					24a. Was a autops perform	y prior	autopsy findings available to completion of cause of 1?
, maga		OR Management to modified			00 Dt (D v)		T.	′es 2□ No
ysician: T	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hcspital: 1 ☐ Inpatie	int 2 ER/Outpatie	ent 3 DOA Ott	26. Place of Death		ence 6 XIOther (5	Group Grecify) Home
ing Ph Mier th uneral	 	27. Manner of Death XXNatural 5 Pending 28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Injur			ow injury occurred	resily Home
	Certification:	2 Accident	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (St City or Town		Rural Route Number,
Hospita 4 hours Funeral ely fille	edical C	29a. Certifier (Check only one) 1 X Certifying Physicien: To the best of Medical Examiner: On the basis of and manner state.	examination and/or i					
To the within 2 To the complet	Med	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signed (M	onth, Day, Year)
- s - o		& Abultaray	YD	D	31391		A pril	7 2006
/		30. Name and address of person and complet use of d	eath (Item 23a) (Type	e, Print)				
<u> </u>		Suhair Abulfarag, M.D. 1	5215 Shady	Grove Ro	ad, #100,	Rockvi	lle, Mary	land 20850
	ate	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature					
Regis	reir	MAY 0 2 2006 Meleuro	0 0% 60	well !				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lapides 2006 Michael /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Balf more City
If Under 1 Year If Under 24 Hrs. 8 pate of Birth he Johns Hopking Hospital Birthplace (State or Foreign Country)
 M 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 0571771941 1 M 2 □ F Days Hours MD 216-38-4792 64 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir then "natural", or itsms 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 □ No N/A **BALTIMORE** Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1102 WASHINGTONVILLE DRIVE 21210 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: WHITE Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FACILITIES DIRECTOR CIENA CORP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If Item 27 Is marked oth any liqury or other traumatic svent 9DRB. LAPIDES ROSS JEAN MORTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1102 WASHINGTONVILLE DRIVE - BALTIMORE, MD 21210 SUZANNE LAPIDES / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI TFILOH CEMETERY 5/1 06 WOODLAWN, MD 4 Donation 5 Other (Specify) uneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-tause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner 6 days Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the buriel-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ Cliobiastome yeltiforme, Aplastic Anenia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b director, page 2 s autopsy performed? 2□ No 1 Tyes or Attending Physician: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of to the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0063682 April 29 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe Bollinore MD 21287 Koeni 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 2 2006 & South Registrar

			1 - For State Registrar	State of M	aryland / [nent of Hocate of L			giene Reg! No.	3741
	Physici		1. Decedent's Name (First, Middle, La Marguerite McKee						2. Date of Dea	ath Day	Year 3. Time of Death
3	/Medic Examin		4a. Facility Name (If not institution, given the second	e street and number	TAL	4b.	City, Town, or	Location of Deat	h	4c County of	V
	Funeral Director		5. Social Security Number 6.		ge (In yrs. last birt		Under 1 Year Inths Days	Il Under 24 Hrs. Hours Min.			9. Birthplace (State or Foreign Country) Canada
	ehow	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town		n				10d. Inside City Limits 1 ☐ Yes 2√2 No
	deeth with the Maryland me 23a or 28e-f ehow r must be notified at	Director	MD Alleg 10e. Street and Number 229 Baltimore Av		Cumbe		of. Zip Code			10g. Citizen ol W	
_	d within 72 hours after deeth with the Marylar speed. 1966. 11. Then "natural", or liteme 23e or 28e-f show then then natified at the Modical Examiner must be mailfied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 _ Yes _ 2 & If Yes, Give Year or Dates:	Ever in U.S.	If Yes	21502 Decedent of His, specify Cubar es 2\sum No	spanic Origin? (S n, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)		- American Indian, , White, etc. White
1215-0036	within 72 ho ene. than "natur ne Medicel I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	(Give kind life. DO N	OT use retired)	urina most of wo	rking	16b. Kind of Bus	siness/Industry
N D L	be file itat Hyg id othe event,	To Be Co	8 17. Father's Name (First, Middle, Las. John Vincent Ear			Housev	wile			Own Home Maiden Sumame Sherwood)
	s 1 end 2 should f Heeith and Men from 27 le marke other traumatic		19a. Informant's Name/Relationship Raymond McKee/so	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	24	⊢Blai	r Stre	nd Number or Ru	ural Route Numbe	er, City or Town, S	State, Zip Code)
Baltimore,	Page nent o ant: # ury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 [4 ☑ Donation 5 □ Other (Special Service 1) ce	ty)	20b. Place of cemeter	y, cremator	y or other place		Date	20c. Location - C	City or Town, State
n n	permit. Departit Import eny Inj		Renald S Renald S 23a. Part I. Enter the disease, or other technologies and failure and the second		of the death. Do n				d 655 W.	. Baltimo	Ore Street Approximate
d	Physician /Medical Examiner		Immediate Cause Final disease or condition resulting in death)	a. Seve	re chi s a consequence o	romic					interval between
8/60,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of						
O. Box 6	ath certifi ittending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time ol death		pic pregnancy er (specify)			23d. Date Mon	of delivery th Day Year
rds, P	The law requires that the de ste has been signed by the e page 2 should be detached f	by	Part II. Other significant conditions Coronary	contributing to death	but not resulting in	the underly	ying cause give	n in Part I.	23e. Did to	•	bute to the cause of death? 3 Probably 4 Unknown
		Completed	acut	pnemon	in le	FIL	vue	·	1 ☐ Yes	osy pr prmed? de 22 No 1	ere autopsy lindings available for to completion of cause of path? □ Yes 2 □ No
on of Vital	ilng Phys After this funeral dii	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 100 27. Manner of eath 1 Natural 5 Pending investigation	Hospital:npat 28a. Date of Inj (Month, D		tpatient 3 Time of njury	DOA Othe	^{nr:} 4 ☐ Nursing H		dence 6 Othe	
Division of	To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not in determined	28e. Place of Ir	njury - At home, fa tc. (Specify)				28f. Location (S City or Tox	Street and Numbe wn, State)	r or Rural Route Number,
	To the Hospital within 24 hours e To the Funeral I completely filled	edicai	29a. Certifier Check only one)	hysician: To the bes miner: On the basis and manner s	of examination and	death dan d/or investig	urrad at the him gation, in my op	e date and plac- inion, death occi	a and due to the urred at the time,	causa(s) and mar date and place, a	nd due to the cause(s)
	To To con	Σ	29b. Signature and title of certifier	m)				number 2 4 4	ŀ	29d. Date signed 4/25/	(Month, Day, Year)
			30. Name and address of person who). LI P	death (Item 23a)		estpora	OM.	21532	11	
- Rep	Sta Regist		31. Date filed (Mopth, Qay, Year)	006 A Hegis	and a signature	George !	-				

			Please				. Ensure All C	•	_	10711
		•	For State Registrar	State of M		rtificate of	Health and Mer <i>Death</i>	Reg. N	. 000	13/42
			1. Decedent's Name (First, Middle, L	ast)				Date of Death		3. Time of Death
	Physicia /Medic		Charles H. Morar	ı Jr.				Month D APRIL	26, 2006	3:10 AM
	Examin		4a. Facility Name (If not institution, g. Saint Joseph		Center	4b. City, Town, o	TOWSON			imore
	Funeral Director		214-26-8988	Sex 7. Ag	e (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min. F	Date of Birth (Month, Day, Yea eb. 5, 1		place (State or Foreign ntry) Yland
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar	ğ	PA yor	k	Red Lion					1 ☐ Yes 2X No
	r 28s	e l	10e. Street and Number			10f. Zip Code		10g. C	Citizen of What Cou	ntry?
	with with	0	309 Winner circ	cle Drive		17356			USA	
	eath ne 2;	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		Hispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No-	14. Race - Ameri	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or Itema 23a or 28a-f show other traumatic event, the Mudical Examiner met by notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? LX Yes 2 If Yes, Give Year or Dates:	No		san', Mexican', Puèrto Rici Specify: White	an, etc.)	Black, White, Specify: Whi	
Ş	hou	ed	15. Decedent's	Education	16a. Dece	dent's Usual Occur	pation	16b.	Kind of Business/In	dustry
5	n 72	et	(Specify only highest g	rade completed)	life.	kind of work done DO NOT use retire	during most of working add)			·
12	withi ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or		enance	•	н	ote1	
7	Hygie Hygie Sther		17. Father's Name (First, Middle, Lat	st)	raint	enance	18. Mother's Name (F		0001	
Ĕ	be f hair hd ol	Be		-						
N N	should be f and Mental b s marked of umatic evs	ဥ	Charles H. Mo		1		Mary Roth			0.11
Maryland	2 sho		19a. Informant's Name/Relationship			•	t and Number or Rural R			
	and ealth n 27		Christa Moran -	Wife			ircle Dr. R			
ē	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Dammual from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	Date	20c.	Location - City or T	own, State
Baltimore,	Peges nent of int: If it iry or o		4 Donation 5 Other (Spec			rematory	Inc. Apr. 2	9 06 19	ltipporo	Maryland
Ħ	orta orta inju		21. Signature of Funeral Service Lio	6 00	2	2 Name and Addre	n Society of	£ Morral	ad Tar	COLYTOID.
B	permit. Peges 1 and 2 Department of Health a important: If item 27 is any injury or other tra ance.		him 1	Ch lan	1001 , 29	Grenation	ick Road Ba	i Maryia Itimoro	MD 21228	10
			23a. Part . Enter the disease, or co shock, or heart failure. List on	mplications that cause	the death. Do not en	ter the mode of dvi	ng, such as cardiac or re	spiratory arrest,	PIO ZIZZA	Approximate
				ly one cause on each	ine.	•				Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_a_ATHER	OSCLEROTI	C CARDI	OVASCULAR	DISEAS	SE.	DECADES
4	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
- 84	Examiner		Sequentially list conditions	b	V-1-11-11-					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury		a consequence of):					
B	dansi	Ē	Cause (Diseese or injury that initiated events	c						
0	executed en and rial-transit	Examiner	resulting in death) Last	Due to (or as	a consequence of):					
92	sicie bur			d						
6876	eath certificate be attending physicit for use as the bu	Completed by Physician/Medical								
×	certii ding se a	×	IF FEMALE:	23c. ff yes, outcome	of pregnancy			9	23d. Date of deliv	erv
Вох	death e atten ed for u	100	23b. Was decedent pregnant in the past 12 months?			□Ectopic pregnanc □ Other (specify) _	EY		Month	Day Year
o	the the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of south	_ Carlot (apcomy) _				
0	that the	F	Part II. Other significant conditions	contributing to death I	out not resulting in the I	inderwing cause or	ven in Part I	23e. Did tobacc	o use contribute to	the cause of death?
	es the	þ		•		moenying cause g	VOITHT CITT.	1 ☐ Yes		babíy 4 Unknown
Records,	w requires that been signed to should be det	ed ed	STATUS POST AOF	KIIC ANEURY	SM REPAIR			I Tes	2 No 3 Fio	bably 4 Molikilowii
ပ္သ	s be	pie	HYPERTENSION					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
æ	The lav ate has page 2	E						performed?	? death?	2□ No
B	icien: Th certificate rector, pag	Ö	25. Was case referred to medical				26. Place of Death (C	-	12 163	20 110
₹	sicien: certific irector,	00	examiner?	Hospital:		of Boal Ot	hor		6 DO:ha- /C	4.0
Division of Vital	this ald		1 Yes 2 No 27. Manner of Death	1 Xinpati		nt 3L DOA	4 Nursing Home	I. Describe how in	6 □Other (Speci fury occurred	197
Ĕ	ding F th. : After s funer	<u>o</u>	1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year) Infury	Wo	ork?]Yes 2 □No		. ,	
Sic	tend death tor: / the f	cat	2 Accident investigat 3 Suicide 6 Could not	bo	N =			Legation /Ct-r-+	and Number or Rur	nd Bouto Alumbra
\geq	ter d irect	Certification:	4 Homicide determine	ad 288. Place of in	ijury - At home, farm, si tc. <i>(Specify)</i>	reet, factory, office	28f	City or Town, St	and wumber or Hur ate)	ai riqute ivumber,
	talo rsafi elDi	Cei		74						
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best	t of my knowledge, dea	th occurred at the to	ime, date and place, and opinion, death occurred	due to the cause	(s) and manner as	stated. to the cause(s)
	he H in 24 he F	Medical	one)	and manner s	tated.					
	To the within To the compl	Σ	29b. Signature and title of certifier	0		29c. Licen	se number	29d. I	Date signed (Month,	Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

MAY 0 2 2006

32. Agistrar's Signature DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 51852

DRIVE TOWSON MARYLAND 21204

		Amend item#2, perMD, g8 1 - State Registrar	State/JP(Nar	yland /	Department of H Certificate of I	lealth and M Death		jiene Reg. Nd. () () (13713
Physici		1. Decedent's Name (First, Middle, Last) MArtha Mitchell					2. Date of Dea Month 04	Day 21 Yeer 12 06	3. Time of Death 02:15A M
/Medio Examir		4a. Fecility Name (If not institution, give st. Ft. Washington Ho			Ft. Was	r Location of Death shington			Georges
Funeral Director		5. Social Security Number 412-42-4739 Usual Residence of Decedent	7. Age ((In yrs. last b	irthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07-04-	r, Year) Co	thplace (State or Foreign puntry) phis, TN.
Maryland febow	tor	10a. State 10b. County Prince Ge			wn or Location Washington				10d. Inside City Limits P☐ Yes 2 ☐ No
death with the Maryland rns 23a or 28e-f ehow rnitet be notified at	al Director	10e. Street and Number 7705 Bock Road			10f. Zip Code 20744			10g. Citizen of What Co	ountry?
ING 21213-UU36 be filed within 72 hours after death with the Marylan lal Hygiene. d other than "naturel", or ltems 23s or 28e-1 show event, the Medical Examiner must be rediffed at	by Funeral	11. Marital Status 11. 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	2. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: B1 a	te, etc.
10 21215-UU36 Filed within 72 hours after I Hygiene. other than "naturel", or Ite	Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Homemaker	ation during most of work d)	ing	16b. Kind of Business	Andustry
and Z d be filed w ntal Hygier ed other ti	Be	17. Father's Name (First, Middle, Last) John Ingram	1 yr.		Homemaker		,	Maiden Sumame)	
OFE, MATYIANG es 1 and 2 should be file of Health and Mental Hy filem 27 is marked other or other traumatic event	10	19a. Informant's Name/Relationship (Type Frances Davis/Daugh			b. Mailing Address (Street 7705 Bock Rd	and Number or Rur		r, City or Town, State,	
Sattimore, semit. Pages 1 ar Separtment of Hea mportant: If Item; nny injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place cemet	of Disposition (Name of ery, crematory or other place Incoln	(8)	Date	20c. Location · City or Brentwood.	Town, State
Baltimore permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service Licensee	200		22. Name and Addre	ss of Facility MA1	shall's	Funeral H	ome
Physician /Medical		23a. Part Enter IV disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line. A the vo	sdero	tic Coronar	y Arteri	or respiratory are	rest, OUSE	Approximate Interval Between Onset and Death
icate be executed physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence	of):				
ath certif	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal deat	h 3 Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
VITAL HECORDS, P.O. I sician: The law requires that the decertificate has been signed by the a rector, page 2 should be detached to	Completed by Ph	Part II. Other significant conditions cont	1	not resulting	in the underlying cause giv	en in Part I.	23e. Did to		o the cause of death? robably 4Unknown utopsy findings available
The The page		25. Was case referred to medical				26. Place of Deat	autop perfor 1 Yes	sy prior to death? 2 No 1 Yes	completion of cause of
on of	ation: To Be	examinar?	spital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b.	Time of 28c. Injur Injury Wor	er: 4 🗌 Nursing Ho	me 5 Resid	ence 6 (Other (Spe	ocify)
UIVISION To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: Atten	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, street, factory, office		28f. Location (S City or Tow	Street and Number or R m, State)	ural Route Number,
he Hospil in 24 hour he Funere pletely fille	Medical ((Check only 2 Madical Examina		xamination a	ge, death occurred at the tir and/or investigation, in my o	pinion, death occur	red at the time, o	date and place, and du	e to the cause(s)
To I vith Com	Σ	29b. Signature and title of certifier		nD	29c. Licens	4674	1	April 2	th, Day, Year) 1, 2006
5		30. Name and address of person who con Deepa K Sachdeva 31. Date filed (Month, Day, Year)	44 0	11711)(Type, Print) LIvingston R	Rd. Ft. Wa	shingto	n, MD. 207	44
Sta Regist	rar	MAY 0 2 20	JZ, Hagistral	J. J.J.	South				
STIMIT I/ nev 1/2	.001			OF	RIGINAL.				

			1 - For State Registrar	State of Maryland		artment of F tificate of		Mental Hy	/giene	.uub	13744
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last Gilbert D.	, McLaughlin :	Sr.			2. Date of D Month May	eath Day	Year 2006	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give Union Memorial 5. Social Security Number 212-56-5428	Hospital		•	imore If Under 24 Hrs. Hours Min.	8. Date of B	irth	9. Birt	holace (State or Foreign
	D.	tor	Usual Residence of Decedent 10a. State 10b. County MD	1 '	Town or Lo						10d. Inside City Limits TX Yes 2 □ No
	th with the 23s or 28s	ai Director	10e. Street and Number 6027 31st Street	eet		10f. Zip Code 21 237	,		10g. Cit	izen of What Co	untry?
036	be filed within 72 hours after death with the Maryland tal Hygiene d other then "naturel", or ltems 23e or 28e-f ehow event, I're Medical Exatricer must be modified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Nas Decedent of H f Yes, specify Cuba I ☐ Yes 2⊠ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	within 72 ho ene. then "natur te Mudical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 9th	ucation fe completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done OO NOT use retired der	during most of work	ang		ind of Business/ Op's We	Industry elding Co.
Maryland 2	D 6 5 0	To Be Co	17. Father's Name (First, Middle, Last) Lenord J. McLa	ughlin			18. Mother's Nam Gladys			Sumame)	
	ges 1 and 2 shoul it of Health and Me if Item 27 is marl or other traumati		John McLaughlir	n /brother	211	_	and Number or Rui		Balt	imore M	ID 21221
Baltimore,	permit. Pages I Department of I Important: If Ite eny injury or ot		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ I 4 □ Donation 5 □ Other (Specify, 21. Signature of Fungral Service Licens	Removal from State Ba	ametery, cren Lyviev	v Cremat	ory 5/2	2/06	Bal	timore	MD
Ba	Deper Impo		23a. Part1. Enter the disease, or companion, or heart failure. List only	Connell			ss of Facility 300 AVE. E			MD 212	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pneumor	lance of):						Onset and Death 2 months
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Chronic Due to (or as a consequence. Acquired	obst ence of):	nuctive	Pulmon	any D	iseas me	se	10 years
58760,	icate be executed physicien and s the burial-transit	edicai Exa	that initiated events resulting in death) Last	Due to (o as a consequence).	ence of):	- To Get 10	acting 5	411300	1110		
P.O. Box 6	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy	,			23d. Date of del Month	ivery Day Year
	w requires that the de been signed by the s should be detached t	þ	Part II. Other significant conditions co	ntributing to death but not resu	ilting in the un	nderlying cause giv	en in Part I.	11	ı		the cause of death?
Division of Vital Records,	:: The law re cete has be : page 2 sho	Completed						24a. Wa auto peri 1 🗆 Yes	s an opsy ormed? 2 Al No	prior to death?	atopsy findings available completion of cause of
<u> </u>	nysician: Th nis certificete director, paq	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♠ No	Hospital: 1 XInpatient 2 □ I	ER/Outpatien	Oth	er: 4 Days of Deal	4.0		2 50 10	2.
ion of	nding Phy ath. r: After this e funeral d	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	4 Li Nuising n	28d. Describe		6 □Other (Speny occurred	criy)
Divis	To the Hospital or Attending Physician: Within 24 hours after death. Te the Funeral Director: After this certifical completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location City or To	(Street an own, State	d Number or Au	ıral Route Number,
	the Hospital hin 24 hours a the Funeral mpletely filled	Medicai		sician: To the best of my know iner: On the basis of examinat and manner stated.							
) //	8		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and ad ress of person who countries of the countries of	BASU, D.	0.	AT24	+38946	,	May	11,200	6
T)		Union Memorial t	tospital, 201	East	Universi	ty PKW	1, Ba	1tim	ore, MO	21218
	Sta Regista	ite ar	31. Date filed (Month, Day, Year) MAY 0 2	32. Redistrar's Signat	de A	poeter					

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of			iene 0 0 6 ag. No.	13745
1	Physici /Medic		1. Decedent's Name (First, Middle, L Anth	ony Z. M	arx			2. Date of Death April	2 gay 200 ga	3. Time of Death 9:15p M
***	Examin		4a. Facility Name (If not institution, g Gilchrist Cer)	4b. City, Town, o	or Location of Death n		4c. County of De Baltin	
*	Funeral Director		105-44-2924	Sex 7. Ag 1□xM 2□F	ge (In yrs. last birthday 54 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb. 11	, 1952 Ne	Birthplace (State or Foreign Sepritr)York
	faryland show	or	Usual Residence of Decedent	more	10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the Mass or 28a-1	Funeral Director	10e. Street and Number 2638 Holly E		d	10f. Zip Code 212	21		0g. Citizen of What	Country?
336	be filed within 72 hours after death with the Maryland Ital Hygiene. Id Hygiene. Id the matural, or Items 23e or 28e-f show event, the Medical Examinating the Legislad at	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 전 If Yes, Give Year or Dates:	!	Was Decedent of HIf Yes, specify Cub. 1 ☐ Yes 2 ☐ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W Specify: W	
21215-0036	within 72 horens. ene. then "nature	Completed	15. Decedent's (Specify only highest g		E.\	DO NOT use retire	pation during most of work d) Y & Acto			ss/Industry certanment cvices
	hould be filed with id Mental Hygiene. marked other that matic event, that	To Be Co	17. Father's Name (First, Middle, Las Kenneth MArx				18. Mother's Name	e (First, Middle, N Goulet		
, Maryland	ulth ar 27 Is r trau	_	19a. Informant's Name/Relationship Camille MArx /			,	and Number or Run Beach I		,	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec		20b. Place of Disp cemetery, cre Meadowr	osition (Name of ematory or other place idge Ce.	ce)		20c. Location - City Baltimo	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Lic	y (on	relly	22. Name and Addre	ss of Facility 30 Funeral	00 MAce Home	Ave. Ba	alto.MD x 21221
3	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	Degene	d the death. Po not er ine.	nter the mode of dyir		or respiratory arrectach role	matic	Approximate Interval Between Onset and Death
,0,	icate be executed physicien and stha burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
.O. Box 68760,	death certiff e attending od for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
S, D	quires that the n signed by the lid be detache	by	Part II. Other significant conditions		out not resulting in the	underlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown
Il Record	The law requires tate has been sign page 2 should be	Completed	artenosder	vlar o	aceide	ents vlaud	lisease	24a. Was ar autops perform 1 Yes 2	y prior t ped? death	autopsy findings available to completion of cause of ?
of Vital	Physician: 7 this certifical al director, p	To Be	25. Was case referred to medical examiner? 1 Yes 250No	Hospital: 1 🗌 Inpati			26. Place of Deat			pecify) Hospice
Division o	or Attending ter death. ir ctor: After n y the fune	ertification:	27. Magner of **ath* 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	be 28e. Place of In	ijury - At home, farm, stc. (Specify)	M 1□	ry at rk? Yes 2 □ No			Rural Route Number,
Ω	Hospite 4 hours Funeral ely fille	calC	29a. Certifier 1 Certifying (Check only one)	Physician: To the best ammer: On the basis of and manner st	or examination and/or is	th occurred at the time	me, date and place,	and due to the ca	ause(s) and manner	as stated. iue to the cause(s)
)	To the within 2 To the Complete	Medi	29b. Signature and title of certifier	2 Rt	aelle	29c. Licens	2564	3 (9d. Date signed (Mc	onth, Day, Year)
1	5		0. Name and address of person who who was a few person who was a few per	o completed cause of a	death (Item 23a) (Type		N. CHAR			
	Sta Registr		31. Date filed (Month, Day, Year)	321Regist	rar's Signature	sele)				

Mar 4, arthory

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year A M. **Physician** MOHR ELMER 7:10 28 April 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. FRANKLIN BALTIMORE 2000 W Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Months 1XM 2□ F Yrs. Director 214 30 6033 1926 118RYLAA Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Modical Examiliar must be multiled at 1 ☐ Yes 2 No SLAD 3007 Directo Cleathano 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA KOAD 3133 1614 BABIKOW death 1 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married White. 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 137RS-BUT WHISHE ON ITERS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EVABARBARA LIRGIL FREDERIC 722055 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31304 item 27 l KICHARO K. ABRAHAM 305 WASHINGTON IHVZ SUTTE 2003 TOWSON MARYLAND MAY Pate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. ► Burial 2 ☐ Cremation 3 ☐ Removal from State KARKWOOD JEEFERY 2006 (ARTILANC 4 □ Donation 5 □ Other (Specify) 21. Sign are of Funeral Setvice Licensee 22. Name and Address of Facility Engra EXECUTE HARPETON ROPO 21234 WILL 18RYLAND TOK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUNG CANCER PAUS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CARCINOMA DAXS COLORECTAL attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 4☐Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown sease 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO061731 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARDEN, MD Franklin Square 9105 GAN-31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 April 24, Jesse Lee Morgan, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Home; 1327 Clipper Heights Avenue Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 01-28-1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) XXM 2□F 214-26-8966 75 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A Baltimore XXYes 2 □ No Maryland

Physician

/Medical

Examiner

10a. State

Funeral

Director

ns 23a or 28s-f show must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag

Division of Vital Records, P.O. Box 68760,<

ai Dir	1327 Clipper Heig	hts Avenue		TOT. ZID Code	2121	1	og. Citizen of What C	USA		
To Be Completed by Funeral Dir	11. Marital Status 1 Never Married 2 Married 3/2/Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? NAYes 2 □ No If Yes, Give Year or Dates: Ko		13. Was Decedent of If Yes, specify Cult	oan, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	14. Race - Am Black, Wh Specify: W			
pieted	15. Decedent's E (Specify only highest gi	rade completed)	(6)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	ipation a during most of w ed)	orking	6b. Kind of Business			
Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Ste	eel Worker				co Steel Co.		
To Be	Jesse Lee Morgan,	_				_{ame (First, Middle, M} ie Mae For	,			
	19a. Informant's Name/Relationship			Mailing Address (Stree						
	William R. Morgan		S	O Marsue D		ampstead,		21074		
	20a. Method of Disposition 1 🖾 Burial 2 🗀 Cremation 3 [4 🗀 Donation 5 🗀 Other (Speci			Disposition (Name of crematory or other places of Faith			Pullerton, $^{\circ}$	_		
	21. Signature of Funeral Service Lice	arpenter		22. Name and Addr Burgee-He: 3631 Fall	ess of Facility nss-Seit s Road	z Funeral Baltimore,	Home, Inc Maryland	• 21211		
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the y one cause on each line.	death. Do no					Approximate Interval Between		
	Immediate Cause (Final disease or condition	- und	inch	NCCR				Inset and Dean		
	resulting in death)	Due to (or as a co	nsequence of):						
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nsequence of):						
Exami	Cause (Diseese or injury that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):						
dicai		d								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of de Month	olivery Day Year		
d by Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in t	he underlying cause g	iven in Part I.	23e. Did tob		to the cause of death?		
ojete						24a. Was ar		utopsy findings available completion of cause of		
mo.						autops; perform	ged? death?	s 2 No		
Be (25. Was case referred to medical examiner?				26. Place of D	eath (Check only one				
70	1 □ Yes 2	Hospital: 1 Inpatient		allerit 3 DOA		Home 5 Peside		ecify)		
Ü.	27. Manner of Death Tatural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Ye.	ar) 28b. Tir Inji	ury W	uryat ork?]Yes 2∐No	28d. Describe ho	w injury occurred			
Sertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be d 28e. Place of Injury - building, etc. (S	At home, farn pecify)	n, street, factory, office	•	28f. Location (Str City or Town	eet and Number or F , State)	Rural Route Number,		
Medical Certificati		Physician: To the best of mariner: On the basis of exa and manner stated.								
M	29b. Signature and title of certifier	2,		29c. Licer	nse number	29	d. Date signed (Mor	nth, Day, Year)		
	100	7	1·10.	рч	4944	P	pa. 26	2006		
	30. Name and address of person who	o completed cause of death	(Item 23a) (T	ype, Print)	-lati	Skeet B	Hane	MajaB		
te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	market	, 1000		, ,, ,,, (

State

Registrar

MAY 0 2 2006

			1 - For State of Maryland	/ Department of Health and M Certificate of Death	ental Hygie Reg.	ZUUD 13/40
	Physicia	an	1. Decedent's Name (First, Middle, Last) Katherine M. M.	loore	2. Date of Death Month	Day. Year 2 12
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April 3	4c County of Death
ŀ	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	ar) 9. Birthplace (State or Foreign Country)
	Director		216-26-7115 1□ M 2 □ F 66 Usual Residence of Decedent	Yrs. Months Days Hours Min.	(Month, Day, Ye July 28,	
	Aaryland f show ed at	or	10a. State 10b. County 10c. City, Maryland Baltimore	Town or Location Dundall	ζ.	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	Irect	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	th with	alD	8513 Kavanagh Road	21222	Uı	nited States
30	a within 72 hours after death with the Maryland piene. r than "natural", or Items 23a or 28a-f show the Marical Examinar must be matified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2反 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
5-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working)	16b	White b. Kind of Business/Industry
2	ithin 7 ne. han "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	ng	
7 0	Hyg than	CO	11 Years 17. Father's Name (First, Middle, Last)	Counter Worker 18. Mother's Name	(First, Middle, Maid	Snack Shack Carryout den Sumame)
yland	ad the se	To Be	Joseph E. Steine	Katheri	ine E. Bed	cker
Mary	2 should and Men is marka aumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura		
	ss 1 and 2 should of Health and Me itam 27 is mark r othar traumation		John Daniel Moore (Husband) 20a. Method of Disposition 20b. Pla	8513 Kavanagh Road I ce of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition Disposition (Name of Disposition Dispos		Maryland 21222 Location - City or Town, State
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Balt	permit. Pages Department of Important: If it any injury or o		21. Signature / Fineral Service 1999	22. Name and Address of Facility Duda-Ruck Funeral F 7922 Wise Ave. Du	Home of Di	ındalk. Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.			Approximate Interval Between
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ļ		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		y can	
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8/60,	cate be executed oblysicien and the burial-transit		resulting in death) Last Due to (or as a conseque	ince or):		
28	tificate ig phys as the	ledical	d			
O. Box	ne death certificate the attending phys hed for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	leath 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
ř.	requires that the de neen signed by the a hould be detached f	by	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Hecords	> 1 0	eted			24a. Was an	24b. Were autopsy findings available
	e las has je 2	Completed			autopsy performed	prior to completion of cause of death?
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
Ö	Phys rthis ral di	. To	27. Manner of Death 28a. Date of Injury 2	28b. Time of 28c. Injury at 2	ne 5 Residence 28d. Describe how in	e 6 Other (Specify)
O	Attending I or death. actor: After by the funer	atlor	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No		
Division	or Atteration of after de Diracto	ertification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or Attent within 24 hours after death To tha Funeral Diractor: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death occurred at the time, date and place, a on and/or investigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Workiechous Ri	Resonoso	4	180/06
	10		30. Name and address of person who completed cause of death (Item 2)	23a) (Type, Print) 2001 Franklin Sawart, I	Drive Bo	Himore Md 21231
	Sta Registr		31. Date filed (Month, Day, Year) 2006 32 Registrar's Signatu	to Sparke)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<u>006</u> Year **Physician** 28, April 5:00A Andrea J. Moreno-Espada /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 11608 Gowrie Court Potomac If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Vrs 11, Slovakia 173-20-2654 Jan. 85 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23s or 28s-f show the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11608 Gowrie Court 20854 United States death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed v
Deperment of Heelih and Mental Hygies
Importent: if Itam 27 is marked other it
any Injury or other traumatic event, the Civil Servant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Stephan P. Barbustiak Julia Kozak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew S. Orochena/Son 15009 126 Barrett Drive, Beaver, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 29 20c. Location - City or Town, State Montgomery riúm, Inc. 2006 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Crematorium. 21. Signature of Funeral Service Ligensee M00803 Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physiclen end I be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificete hes ti lirector, page 2 s autopsy performed? Yes 2. No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner?
1. Yes 2 □ No tor: After this certific the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deal To the Funeral Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jack Epstein, M.D. 10810 Connecticut Avenue, Kensington, Maryland 20895

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#7,8,perFH,0855,5/9/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vest **Physician** 8:34 P Frances Julia Martin McCaffrey April 30, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 9707 Old Georgetown Road #1513 Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1924 (Month, Day, Year) Aug. 28, 1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days Hours 82 81 Washington, D. C. Director 578-24-3062 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10h County r than "natural", or Iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Montgomery Bethesda Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 United States 9707 Old Georgetown Road #1513 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11, Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No White Specify: Specify: þ 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker other 18 Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any Injury or other traumatic event <u>sing.</u> 17. Father's Name (First, Middle, Last) Be Russell B. Martin Julia (Not Available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. McCaffrey III/Son 9839 Lake Shore Drive, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory of other place) Arlington National Cemetery May 19, 20a. Method ol Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal Irom State 2006 Arlington, Virginia 4 □Donation 5 □Other (Specify) Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Ligensee William U. Kunshier M01173 7557 Wisconsin Avenue, Bethesda, MD 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence ol): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown Cerebral Vascular Insufficiency 24b. Were autopsy lindings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 X Yes 2 No 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 5 Pending 1 X Natural 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35791 May 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records, P.

market

M.D.

Lever

32. Registrar's Signature

Vemury,

MAY 0 2 2006

Merlyn K.

31. Date liled (Month, Day, Year)

9801 Georgia Avenue, #227, Silver Spring, MD

	•	For State Registrar	State of M	aryland	•	rtment of F tificate of	lealth and M Death	,	giene Reg. No.)06	13751
Physic	ian	1. Decedent's Name (First, Middle	Last) NIChi	Ci				2. Date of Dea Month	Day 25	Year	3. Time of Death
/Medi Exami		a. Facility Name (If not institution,	give street and number)	1		4b. City, Town, o	or Location of Death	7		unty of Death	0.00
		3126 Gracefield Ro				Silver Sp			Mor	ntgomery	
Funeral Director		213 18 3725	6. Sex 7. A(ge (In yrs. las 92	yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 03 29 19	h /, Year) 914	9. Birthp Cour Mary 1	place (State or Foreign ntry) and
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	10d. Inside City Limits
Mary B-f eh	to	Maryland Montgo	mery	Silve	r Sprin	ng					1 Nes 2 No
or 28	Director	10e. Street and Number				10f. Zip Code			3	of What Cour	ntry?
s 23s	rai	3126 Gracefield Ro	ad Apt. 417	Ever in II S	12.1	20904	Hispanic Origin? (Sp	acify Vas or No-	U.S.	A. Race - Americ	can Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23a or 28a-f show eny injury or other traumatic event, the Modical Exeminar must be notified at eny injury or other traumatic event, the Modical Exeminar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	Armed Forces	? No		f Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		Black, White,	
72 ho	eted	15. Decedent (Specify only highes	s Education t grade completed)		(Give	ient's Usual Occup kind of work done	during most of work.	ing	16b. Kind	of Business/In	dustry
Mithin one.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire	d)		Own	Home	
filed v Hygie of the r	ပိ	17. Father's Name (First, Middle, I			Homen	акег	18. Mother's Name	e (First, Middle,			· · · · · ·
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other then "neturel", or traumatic event, the Mudical Exem	To Be	John Flester					Margaret M	urphy			
ary and N	6	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street	and Number or Run		r, City or To	wn, State, Zip	Code)
and and the magnetic magnetic per tree magnetic		Bernard Nichols,	Son	20h Pla	2108 C	Chesapeak Facilities sition (Name of	larbor, Anna	polis, Md		ion - City or To	oum State
TOTE TO THE STATE OF OF OF OF		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation		cer	netery, crer	natory or other pla	ce)				
altimore, mit. Pages 1 ar partment of Hea portent: if item y injury or other		4 □Donation 5 □ Other (Sp 21. Signature of Funeral Service I		Unic	on Ceme	tery Name and Addre	04 28	8 06 Fleck Fu			, Maryland
Degraphia		Maxande		<u>.</u>		7601 01	d Sandy Spr	ing Road,	Laure1	, MD 207	707
		23a. Part1. Enter the disease, or shock, or heart failure. List	complication that cause	d the death.	Do not ent	er the myde of dyi	ng, si ch as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Atker	wscle	Lotic	Mean	- Isla	8C		I	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	s a conseque	ence of):						0
Ladiminer		Sequentially list conditions,	b. Due to (or a	s a conseque	nce of):						
uted L	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events		,							
O, A exec en an	Exa	resulting in death) Last	c. Due to (or a	s a conseque	ence of):						
18760, Cate be executed physicien and the burial-transit	dicai		d.							-	
X 6		IF FEMALE:	23c. If yes, outcome	e of pregnance	cv				23d	. Date of delive	en/
I Records, P.O. Box 6 The law requires that the death certificate as been signed by the ettending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No	1 Live birth 4 Pregnant a			Ectopic pregnand Other (specify) _	y			Month	Day Year
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Vital Records, sician: The law requires t certificate as been signe irector, page 2 should be		OF Man ages referred to madical			January Commen		00 Pt - (P	1 ☐ Yes	201No	1 ☐ Yes	2□ No
of Vita Physician: rthis certific ral director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat	ient 2□E	R/Outpatier	nt 3 DOA Ct	26. Place of Deat her: 4 \(\sum \) Nursing Ho			Other (Specia	(v)
of Physical Control	ı.	27. Manner of Death	28a. Date of In	jury 2	28b. Time o			28d. Describe I			,,
Vision Attending r death. sctor: After	atic	1 Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	pation				Yes 2 □ No				
E Parts	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place of Ir	njury - At hom etc. (Specify)	ne, farm, sti	eet, factory, office		28f. Location (S City or Tov		lum <i>ber</i> or Run	al Route Number,
Hospitel Hospitel Punars Funars Intely filled	edical ((Check only 2 Medical	g Physicien: To the bes Examiner: On the basis	of examination	ledge, deat on and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time.	cause(s) and pla	d manner as s	stated. o the cause(s)
To the h within 24 To the F complete	Med	29b. Signature and title of certifie	and manner s	stated.		29c. Licen	se, number		29d. Date 9	aned (Month,	Day, Year)
5 ¥ ii o		MAPA DI	(1) seithar			7000	1337		4/	28/86	, ,
1		30. Name and address of person	who completed cause of	death (Item :	23a) (Type.	Print)	-0/3		-/-	100	
2		Dr. Karen Merritt	·			,	Maryland 209	004			
	tate	31. Date filed (Month, Day, Year)	32. Regis	tcar's Signatu		-					
Regis	_	MAY 0	2 2006	10 0 m	K	fresh,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 29d, 30 per DVR, 05/02/06dhb 8 per FH Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 16:45 PM Oliver 112abeth 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Belair

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1917 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1917 | N. C. ChesaPeake 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2 1 F 240-46-2313 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 ie marked other than "natural", or itama 23a or 28a-f ehow other treumatic event, the Modical Exeminar must be notified at 1 ☐ Yes 2 No Joppa Director Hartord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 | Yes | 2 | No 21085 USA 625 Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 □ Divorced and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Jomestic () ww 8 +h 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 4/27/06 Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) Daughter in law Francis Cribbs-Prince 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any injury or other tre once. Franci 21085 625 Falcon Bridge D rive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10 le Catonsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 5240 Ruisterstown Ad Baltimore 23a. Paril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Premonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð After this certificete has been signifuneral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 400 Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No 1 - npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funarel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Swett, M.D., Upper Chesapeake Medical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Teller

H0063138

April 27, 2006

			State of Maryland / Department of Health and Mental Hygiene	
			1 - For State Ragistrar Certificate of Death Rag. No. 0 16 3753	
	Physici	20	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	
	/Medic		ROBERT ORLOPP APRIL 28, 2006 ITTIP	M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		181	JOHNS HOPKINIS BAY VIEW MEDICAL CENTER BAYTMORE N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore	eion
:	Funeral Director		436-39-7914 1XI M 2 F 32 Yrs. Months Days Hours Min. (Month, Day, Year) Country) LOUISIANA Usual Residence of Decedent	
	/land		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	nits
	within 72 hours after death with the Maryland ene. then "natural", or itama 23a or 28a-f ehow Ita Madical Exeminar must be nutified at	by Funeral Director	MD BALTIMORE PARKVILLE 1 Q Yes 2 M	No
	or 28	Oire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	ath w	S	3014 CHESLEY AVENUE 21234 USA	
	itams itams	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
336	urs aft	by	1 Never Married 2 Married 1	
21215-0036	"natural",	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	
21	ithin	npie	Elementary/Secondary (0-12) College (1-4or 5+)	
	a filed withir il Hygiene. other then		10TH GRADE DISABLED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
anc	ould be fi Mental H arked ot atic ever	Be	ROBERT P. ORLOPP, JR. BONNIE DEVLIN	
Maryland	COEE	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	and 2 sealth ar n 27 is		BONNIE D. ORLOPP/MOTHER 3014 CHESLEY AVENUE BALTIMORE, MD 21234	
ore,	of Head		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Ē	Pages ment of ant: if it ury or o		4 Donation 5 Other (Specify) METRO CREMATORY, INC. 5/1/2006 CATONSVILLE, MD	
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or othar tr once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286	
760, 1	Physician /Medical Examiner und physicien an	licai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and any, leading to min collate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Sectopic pregnancy 1 Other (specify) 23d. Date of delivery Month Day Year	
	s that ned by e deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	,
rd	w requires that been signed E should be deta	ted	MORBID OBESITY 1 Yes 2 No 3 Probably 4 Unkno	WI
Records,	sician: The law n certificate has be irector, page 2 sh	ompie	24a. Was an autopsy findings availa autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No	ibl <i>e</i> of
ital		Bec	25. Was case referred to medical examiner?	
<u>></u>	hysic his ce Il dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
Division of Vital	Attending Physician: r death. sctor: After this certificator; by the funeral director.	Certification:	27. Manner of Death 1 Schatural 5 Pending (Month, Day Year) 1 Schatural 5 pending (Month, Day Year) 1 Schatural 5 pending (Month, Day Year) 1 Schatural 5 pending (Month, Day Year) 1 Schatural 5 pending (Month, Day Year)	
isi	death ctor: , the	licat	3 Suicide 6 Could not be aga Blace of Injury. At home farm street follows office. 281 Location (Street and Number of Bural Bouts Number)	
Θį	after after Dire	erti	4 Homicide determined building, etc. (Specify)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)	
			Medical Resident RES-000 APRIL 28, 2006	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTORIA MOSLEY LOC N. WOLFE STREET BALTIMORE, MD 21287	
	Sta Registi		31. Date filed (Month, Day, Year) 82. Registrar's Signature MAY 0 2 2006	

			1 - For State Registrar	State of N	Maryland / Dep	oartment e ertificate				giene Reg. No.	16	13754
	Physici /Medic		Decedent's Name (First, Middle, Last Doris Porterfield						2. Date of De. Month April	Day 200	Year 06	3. Time of Death 4:32 a M
	Examin		4a. Facility Name (If not institution, give Homewood at Willi	street and number	ar)		wn, or Local		th		ingto	
	Funeral Director		220-18-2428	9x 7 □ M 2⊠F	Age (In yrs. last birthda 81 Yrs.	y) If Under 1	Year If Ur Days Hou	ider 24 Hrs		th v. Year)	9. Birtl	hplace (State or Foreign untry) yland
	e Maryland la-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD Washing	gton	10c. City, Town or Hagerst							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with th	al Director	10e. Sireet and Number 11215 Youngstown	Drive		10f. Zip Ci				10g. Citizen o	₫ What Co	untry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Ie marked other then "naturel", or iteme 23e or 28e-f ehow other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? ⊠ No	3. Was Deceder If Yes, specify 1 ☐ Yes 218	Cuban, Me	kican, Puer	Specify Yes or No to Rican, etc.)		lack, While	ncan Indian, e, etc. ite
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		or 5+) (Gi	edent's Usual (ve kind of work of DO NOT use)	done during retired)		orking	16b. Kind of		Industry
land 2	ould be filed within Mental Hygiene. arked other than ' atic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Claude Knode Hum			CHOIL D	18. N	lother's Na	me (First, Middle,	Maiden Sum	,	
Mary	nd 2 should be Ith and Mental 27 le marked o r traumatic eve		19a. Informant's Name/Relationship (7 David Porterfiel				Street and N	mber or R	Wartins	er, City or Tow	m, State, Z	
Baltimore,	m Q		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from Sta	20b. Place of Dis	position (Name rematory or othe	of	#102	Date	20c. Location	n - City or	Town, Slate
Balt	permit. Page Department Importent: If eny injury or once.		21. Signature Funeral Service Licen	rade, Byr	all	22. Name and a State And Baltimon			d 655 W.	Balti	more	Street
8760,	death certificate be executed e attending physician and purial-transit for use as the burial-transit	ledical Examiner	23a. Part1. Enter the disease, or complete shock, or beart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence of): as a consequence of): as a consequence of):	\ /	dying, suc			rrest,		Approximate injuryal Between Chast and Death
P.O. Box 68	death certif e attending od for use a	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 N No 9 □ Unknown		2 ☐ Fetal death :	B⊟Ectopic preg 5 ☐ Other (spec					Date of deli Month	ivery Day Year
Vital Records, P	e law requires hes been sign je 2 should be	Completed by Pl	Part II. Other significant conditions of	ontributing to death		underlying cau		Part I.	1 🗆 '	Yes 2 (No an 24t	3 □ Prob. Were au	utopsy findings available completion of cause of
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Place of De	eath (Check only o			
Division of \	d S	ation: To	1 Yes 2 No 27. Manner of De th 1 Vatural 5 Pending 2 Accident investigation	28a. Date of li (Month, i	-	of 280	Other: 4 Injury at Work? 1 Yes		Home 5 Resident Resid		1 /	cify)
Divis	를 를 들	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Flace 0	Injury - At home, farm, etc. (Specify)	street, factory, o	office		28f. Location (S City or Tox	Street and Nut vn, State)	nber or Ru	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier 1 Certifying Fin (Check only 2 Medical Exam	ystcian: To the be niner: On the basis and manner	ist of my knowledge, de s of examination and/or stated.	ath occurred at investigation, in	tne time, da i my opinion	e and plac death occ	e, and due to the turred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
)	To the within to the total	×	29b. Signatufelagy misso striffier	Anasi (M	r Dintern	29c. l	icense num	706		29d. Date sign	ned (Monti	h, Day, Year)
			30. Name and address of person with	completed cause of	of death (tem 23a) (Typ	e, Print)	· Au	- 1	HAGGIST	ceur,	Wed	21742
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	and I		1	,			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death PIEMCE Physician CHARLES 900 S 640 AM 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTER BATMORE JOHNS HOPKINS CARE BALTIMONE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**™**M 2□ F 216-10-0258 Director Usual Residence of Decedent the Maryland 10b. County 10c, City. Town or Location 10d. Inside City Limits 10a. State ral', or Items 23a or 28e-f show Examiner must be notified at 1 X Yes 2 ☐ No MD Baltimore Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21211 3035 Huntingdon Avenue United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If Item 27 Is marked other then "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Factory College (1-4or 5+) Elementary/Secondary (0-12) Maintenance Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Katherine Kirschnick Charles Henry Pierce, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Herman Walter Pierce/Brother 3035 Huntingdon Avenue Baltimore, MD 21211 Department of Health a tmportant: If Item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date May 1 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2006 A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 28900 M Mull 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMENTIA Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: use : 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown ۾ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 20 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospitał: 1 ☐ Inpatient Other. 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) P this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification; Hospitel or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after o determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier D3+080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYULEN (N. BATTIMONE MO LEFF BRULE 5505 31. Date filed (Month, Day, Year) 32 registrar's Signature State MAY 0 2 2006 Registrar

	-50.0		1 - State Registrar	State of Ma					Death			Reg. No		10/00
(100)	Physicia	an	 Decedent's Name (First, Middle, Last) Lisa Marie McGar 	vey Porte	er						2. Date of D Month	Da		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s				4b. City.	Town, or	Location o		April	29	2006 c. County of Dear	<u>9:50a</u> ™
-	Examin	er *	7203 Patton Drive					lbine					Carroll	
45.	Funeral Director		219-70-3772	7. Age 34		rst birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, D Jan 14	Day, Year,) Co	thplace (State or Foreign buntry)
	land		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation							10d. Inside City Limits
	e Man a-f sh ilied	ctor	Md Carroll		Wood	lbine								1 ☐ Yes 2 MNo
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. In Medical Examination must be notified at once.	Director	10e. Street and Number 7203 Patton Drive				10f. Zip	Code 797				10g. Ci	itizen of What Co	ountry?
	ms 23	Funerai	11. Marital Status	2. Was Decedent I	Ever in U.S	S. 13. V	Vas Dece	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or N Rican, etc.)	io-	14. Race - Ame	
ထ္ထ	or Ite	y Fur	1 Never Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give X	40	1	Yes, spe		n, Mexican Specify:	, Puerto	Hican, etc.)		Black, Whit	
Ş	hours turat',	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		16a. Deced						16h k	Kind of Business	
215	nin 72 in "na	Completed	(Specify only highest grade		i+)	(Give	kind of wo OO NOT u	rk done a	luring most	t of worki	ng	100.1	and of basiness	modotry
212	ed with ygjene tarthe	Сош		+4	.,	re	giste	ered	nurse				ealth ca	re
Maryland 21215-0036	ntal H ed oth	To Be	17. Father's Name (First, Middle, Last) Philip James McGa	rvov							o (First, Middl nine Wa		n Sumame)	
<u> </u>	should nd Mei mark imatic	2	19a. Informant's Name/Relationship (Ty)			19b. Mailin	g Address	(Street a					or Town, State,	Zip Code)
Mag.	and 2 alth at 27 is er trau		William F. Porter	(spouse)		7203	Patto	n Dr	., Wo	odbi	ne, Mo	1 217	797	
Baltimore,	of He of He If Item or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	Ce	ace of Dispos	natory or o	ther place			Date		ocation - City or	
<u>=</u>	it. Pag rtment rtant: njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	10	wesı	ley Fr				5-5-0	_		kesville	•
Ba	Depa Impo any i		Part1. Enter the disease, or compli	nbert		P	.O. E	Sox 1	95 Sy	kesv	ville,	Md 2	21784	& Chape1
	Physician /Medical Examiner b physician and Examiner its the prival-transit	ai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):	72	EA	_ (RCIN		A	Interval Between Onset and Death
687	ficate physis the	edic	,					_						
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	lEctopic pi Other (sp						23d. Date of de Month	livery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tnbuting to death b	ut not resul	lting in the ur	nderlying o	ause give	en in Part I.					o the cause of death?
Reco	The law re ite has bee bage 2 sho	Completed										opsy formed?	prior to death?	utopsy findings available completion of cause of
/ital	clan: ertifica ector, p	Bec	25. Was case referred to medical examiner?							of Death	(Check only			
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatie 28a. Date of Inju (Month, Da)	ry.	ER/Outpatien 28b. Time of Injury		28c. Injury Work	at		me 5X Re 28d. Describe		6 □Other (Speury occurred	ecify)
Jivisi	or Atter after dea Diractor in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.			eet, factor	y, office				(Street a own, Stat		ural Route Number,
_	To the Hospital within 24 hours a Yo the Funeral Completely filled	Medical Co	29a. Certifier Certifying Phys (Check only 2 Medical Examin	ician: To the best	examinati	vledge, death ion and/or inv	occurred restigation	at the tim , in my op	ie, date an pinion, dea	d place, a	and due to the	e cause(s	s) and manner as nd place, and due	s stated. e to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier	M d	01	10	290	c. License	number	419		29d. Da	ate signed (Mont	
•			30. Name and addres of person who co	mpleted cluse	eath (Item	23a) (Type,	Print)	1		11/		1 16	4 110	2006
(3) (3)	Sta Registr		DIANA H. GRI 31. Date filed (Month, Day, Year) MAY 0.2. 2006	32 Registra	190	000	ATOI	1 H	VEN	uE,	BAL	TIM	DRE M	D 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death o 2. Date of Death APRIL 21:50M -alleobhai 27,2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE AGNES HOSPITAL Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1,2 M 2□ F 013 64 3567 91 Yrs. INDIA 1/1/1915 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore octonsuille 10e. Street and Number 10g. Citizen of What Country? Nati U.S.A. altimore 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) \Im N/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dhayabhai Jangaben 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5701 Baltimore Natil. Pike CatusuilkHD21200 <u>Veswant</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 30/06 Baltimore Washingto Cross 41 Laurel MD2070 22. Name and Address of Facility Fleck Funeral Home 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SpringRd. Laurel HD 20707 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA Week Due to (or as a consequence of) FAILURG RENAL ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): HEART FAILURE CONGESTIVE months Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy ormed? 2 10 No 1 ☐ Yes 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (Inpatient 2 ER/Outpatient 3 DOA

/Medical Examiner P.O. Box 68760, Records. Division of Vital Afte death. Director: filled in by within 24 hours after To the Funeral Dire

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ö

and Mental Hygiene.

permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any njury or other trau once.

Physician

Examine

Baltimore, Maryland 21215-0036

the Medical Examinar must be notified at

Director

Funeral

þ

Completed

ģ Completed Be Medical Certification: To 4 Homicide 29a. Certifier

Physician/Medical 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 (Natural 2 Accident 3 T Suicide

5 Pending

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 2 Certifying Physician: To the hest of my knowledge death occurred at the time data and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HUSPITAL, BALTIMORE, MD

(Check only one) 29b. Signature and title of certifle

29c. License number

GNES

29d. Date signed (Month, Day, Year)

30. Name and address of erson who completed cause of death (Item 23a) (T pe, Prin KUSTOGI, MID

State Registrar 31. Date filed (Month, Day, Year) 02 2006



			For State	Sta	te of Maryl		partmei <i>ertifica</i>			_	200	006	13758	
			Registrar 1. Decedent's Name (First, Midd	le, Last)			ertinca	ie oi D	Calli	2. Date of De	Reg. No.		3. Time of Death	_
	Physici		Emory A. Plitt	, Sr.						APR	Day 3	200 Year		
	/Medic Examin		4a. Facility Name (If not institution						ocation of Death		4c.	County of Dea	ath	
			St Agnes	17057				altin	\s(C)	10.5		N/A	(0)	
- 1	Funeral Director		5. Social Security Number 213-03-2742	6. Sex 1 AM 2		yrs. last birthd	Months		Hours Min.	8. Date of Bir (Month, Da Dec. 3	y, Year) 192	1 0	rthplace (State or Foreign country) ryland	1
	and		Usual Residence of Decedent 10a. State 10b. Count	,	10c.	. City, Town o	r Location						10d. Inside City Limits	
	death with the Maryland me 23a or 28a-f show roust be notified at	ţo	MD Bal	timore			Arbu	ıtus					1 ☐ Yes 2Ã ☐ No	
	h the	lec	10e. Street and Number				10f. Z	ip Code			10g. Citi	zen of What C	ountry?	
	th wit	a D	5530 Ashbourne	Road				21	227		Ur	nited S	tates	
Maryland 21215-0036	b 2 8	by Funeral Director	11. Marital Status 1 □ Never Married 2 🛣 Ma 3 □ Widowed 4 □ Divorce	rried 1 1	s Decedent Ever i ned Forces? XYes 2 □ No es, Give ar or Dates:	in U.S.	I3. Was Dece If Yes, sp 1 ☐ Yes		panic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Am Black, Wh Specify: W		
5-0	72 hc	etec	15. Decede (Specify only high	nt's Education est grade comp	oleted)	16a. De	ecedent's Usi ive kind of w	uai Occupat ork done du	ion ring most of won	king		nd of Busines: imore	s/Industry	
121	within one.	Completed	Elementary/Secondary (0-12)	Co	llege (1-4or 5+)		ss Roc						Company	
Q 22	filed v Hygie ther t		17. Father's Name (First, Middle	, Last)		110	SS ROC		18. Mother's Nan	ne (First, Middle	1	-	Company	_
an	id be ental ked o	To Be	Louis A. Plitt	. Sr.					Minnie 1	B. Jacol	s			
ar≥	shou and M mar	1 7	19a. Informant's Name/Relation		nt)	19b. M	ailing Addres	ss (Street ar	nd Number or Ru	ral Route Numb	er, City o	r Town, State,	Zip Code)	_
Σ	and 2		Catherine M. I	litt V	Wife	100000000000000000000000000000000000000			Rd., A:					
Baltimore,	Pages 1 lent of He nt: if iten ry or oth		20a. Method of Disposition 1 Burial 2 Cremation 1 Donation 5 Other (at from State	ob. Place of D cemetery, Vest Ar remato	isposition (Na crematory or undel rv	ame of other place,	5-1	Date -2006		ocation - City o		
Balti	permit. Departm Importa any inju		21. Sunature of Funeral Service	Licensee	avali	H		and Address	of Facility Am		ınea1	L Home,	Inc.	
			23a. Part1. Enter the disease, of	or polications	s that caused the	death. o not						icus, n	Approximate Interval Between	
	Physician /Medical Examiner		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_ a	Verwhel Due to (or as a con		Sepsis	Fron	m intrac	bdomi-	al i	nfection	Onset and Death	
	icate be executed physicien and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	Oue to (or as a con									
68760.	cate be c ohysicies the buri	edical		d										_
O. Box	ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1	res, outcome of productions of produ	Fetal death	3 □Ectopic 5 □ Other (s					23d. Date of de Month	elivery Day Year	
EMORY Ecords, P.	uires thet the de n signed by the e		Part II. Other significant condit	Λ .	1 1	_	ne underlying				tobacco u Yes 21		to the cause of death? Probably 4 □Unknown	ì
Œ	The law require ete has been sig page 2 should b	Completed by	bowel obstr	nction						24a. Was auto perfe 1 Yes		prior to death?		,
Vital	sician: Th certificete irector, pag	Bec	25. Was case referred to medic examiner?	al					26. Place of Dea			i t		
L V	hysic his ce	မ	1 Yes 2 No	Hospita	1 Minpatient	2 ER/Outpa			4 ☐ Nursing H	ome 5 Res			ecify)	
	Jing After fune	atlon;	27. Manner of Death 1 ☑Natural 5 ☐ Pend 2 ☐ Accident inves	28a ing tigation	. Date of Injury (Month, Day Yea	28b. Tim Inju	e of ry M	28c, Injury Work? 1 🗆 Y	at ? es 2 □ No	28d. Describe	how injur	y occurred		
PL Division	al or Atte s after de il Directo	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be mined 28e	. Place of Injury building, etc. (Sp	At home, farm oecify)	, street, facto	ory, office		28f. Location (City or To			Rural Route Number,	
	To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certify (Check only 2 Medice	I Examiner: O	To the best of my n the basis of exam nd manner stated.	knowledge, omination and/o	leath occurre or investigation	d at the time on, in my opi	e, date and place nion, death occu	, and due to the irred at the time,	cause(s) date and	and manner a d place, and du	as stated. ue to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifi	A. Bast	MD, VIN)	2	9c. License					nth, Day, Year)	
	12		30. Name and address of perso			(Item 23a) (Ty	/pe, Print)		38618362				10,2006 1D 21229	
1	Sta	ate	31. Date filed (Month, Day, Yea		32 Registrar's S	Hospi Gignature		100	uren r	1461 12	OCIFIC	(2/11/6)		_
	Regist	rar	MAY 0 2	, 4000	The State of the State of	July July								

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 3:00 AM PARRISH APRIL 2006 MINA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL CENTER BALTIMORE Baltimore City HARBOR If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days 1 ☐ M 2 🗓 F 212-26-2377 Director June 30, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at XXYes 2 □ No Director Baltimore Baltimore City 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours effer death with Department of Health and Mental Hygiene. Important: If them 27 ie marked other then """ any highry or other traumest. 21225 USA 3422 7th Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify. White 1 ☐ Yes 2XXXNo Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaner Dry Cleaners 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Deona Wilkinson William Forest Turnbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 Crestwood Drive, Edgewood, Maryland 21040 Mrs. Juanita M. Carroll / niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 05/02/2006 Chesapeake Cremation Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Ave SW, Glen Burnie, MD 21061 MO1357 ancus 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA ASPIRATION Physician WEEK /Medical Due to (or as a consequence of): Examiner > 3 MONTHS MALNUTRITION SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner >2 WEEK or Attending Physician: The law requires that the death certificate be executed use as the burial-transit DEHYDRATION attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) APRIL 30 2006 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š page 2 should be ATRIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FIBRILATION. Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed 2 □ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Minpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified RES 001 APRIL 30,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH HANOVER STREET, BALTIMORE, MARYLAND 2122/5 3001 ADJE 31. Date filed (Month, Day, Year) 32. pgistrar's Signature State Registrar MAY 0 2

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death 25° 2006° ar **Physician** April 12:20 рм Paraskevas Peltsemes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Baltimore 11 Carriage Lamp Court | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Greece Director 214-38-5398 70 1935 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f show 1 Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11 Carriage Lamp Court 21234 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 le marked other than "natural", or Item Into other than "natural", or Item Iny or other traumatic event, II a Madical Earin and Iny or other traumatic event, II a Madical Earin and 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 0wner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Theodore Peltsemes Eleni Margaritis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peltsemes Wife 11 Carriage Lamp Court Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removat from State permit, Page Department of Important: If any injury or once. Dona 5 Other (Specify) St. Demetrios Cem. 4-28-2006 Cub Hill 21. Signatore Funeral Service Licensee ^{22. Name and Address of Faculty}
Ruck Towson Funeral Home, Inc 1050 York Rd. Towson, Md. 212 Towson, Mdí 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List jonly one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Finat **Physician** myo cards disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORONARY Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 9 1 XYes 2 No 3 Probably 4 Unknown tor: After this certificate has been si the funeral director, page 2 should? Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No bro Vascul 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one | Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after on Funeral Direct filled in by 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The distance of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YORK Rd , S+ 102, TOWSON, MD, 21204 LIGNOS M.D. EVANGELOS 7801 32. segistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

			1 - For State Registrar	State of Maryla	nd / Dep		t of H		Mental Hyg	giene	06	13762
	Physici	an	1. Decedent's Name (First, Middle, La	st)		./	21		2. Date of Dea	ith Day	Year	3. Time of Death
	Physici /Medio		NAOm.	17.		17	9/14	DAUM	April	217, 2	2006	11:32 PM
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	Funeral Director		5. Social Security Number 6. S 354-12-4254	D11 00 F	. last birthday 35 Yrs.	Months	Days	Hours Min.	8. Date of Birth Month, Day 08/04	/fg20	ALA	lace (State or Foreign
			Usual Residence of Decedent	Λ	,,,				00/04	71320	/////	27 (1 17 (
	yland		10a. State 10b. County	10c. C	ity, Town or L	ocation					1	0d. Inside City Limits
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	r dez	ne	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13	Was Deced	lent of Hi	ispanic Origin? (Si in, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Ra Bi	ice - Americ ack, White,	
36	s afte	Ž.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 No If Yes, Give		1 ☐ Yes	2 X) No	Specify:		Spec	ify:	WHITE
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	005 4 Q		ALWW IVI	um							ILLE,	MD 21208
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. B	deal	sicia	in the past 12 months?	4 Pregnant at time of		Other (sp				N	lonth	Day Year
P.O	The law requires that the death certifica lie hes been signed by the attending ph bage 2 should be deteched for use as th	Physiclan/Med	9 Unknown		4.		-		1 00 511			
	res that igned to be dete	۾	Part II. Other significant conditions	ontributing to death but not re	sulting in the	underlying c	ause give	en in Part I.	1		_	ne cause of death?
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Division of Vital Records,	e law hes b	Completed	Acute KENAl	FAILURE					24a. Was a autops perfor	sy	. Were auto prior to cor death?	psy findings available mpletion of cause of
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	hour hour uner ly fille		29a. Certifier 1 Certifying Ph	nysician: To the best of my kn niner: On the basis of examin	nowledge, dea	th occurred	at the tim	ne, date and place	, and due to the o	ause(s) and r	nanner as si	lated.
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	Medical	one)	and manner stated.				e number				
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ann 10:50 PM 26, Judith April 2006 UIMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13425 Cloverdale Place Montgomery Germantown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Yrs. 579-58-8618 February 9, 1946 Pennsylvania 60 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or iteme 23a or 28e-f ehow edical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13425 Cloverdale Place 20874 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after nent of Heelih end Mental thygiene. Int: If Item 27 le marked other than "naturel; or Ite Iny or other treumatic event, the Medical Engine. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: 2 Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Energy Elementary/Secondary (0-12) College (1-4or 5+) and Commerce Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond B. Malloy Jane Mores ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Mason/Daughter 19905 Mastenbrook Place, Montgomery Village, MD. 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) April 30, 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) 2006 Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee Medette M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Days **Physician** Intracerebral Edema /Medical resulting in death) Due to (or as a consequence of) Examiner Recurrent Glioblastoma 2 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed the attending physicien and hed for use es the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No deteched 9 Unknown 9 Unknown ۾ signed Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 hes autopsy performed? certificete 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14626 April 26, 2006 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 West 7th Street, Frederick, Maryland 21701 Paul Rausch, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day 2006 Month **Physician** Anthony Rossi, Jr. 12:30P M Carmen April 25, /Medical 4h. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Dundalk 8201 Cornwall Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Davs Hours 1 ₹M 2 ☐ F 216-20-0947 78 Mary1and Director March 21,1928 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 | Yes 2 | No Dundalk Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 8201 Cornwall Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: 1946-49 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Itema Black, White, etc. filed within 72 hours after 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 Yes 25 No Specify: þ 3 Widowed 4 Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 Is marked other then 'any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Eastern Stainless Stee. Shearman 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mamie Goldstein Carmen A. Rossi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8201 Cornwall Road Dundalk, Maryland (Wife) Barbara Rossi Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of metery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11top Service Corp. 4/29/2006 Towson, Maryland 57 Other (Specify) 4 Donation 21. Signature neral Salvice Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 months **Physician** Metastatic MALayona /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Pa Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s this certificate 1 Yes 2 No Division of Vital or Attending Physicien: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: 1 Natural 2 Accident 5 Pending after death. 1 TYes 2 No М 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral E
completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0034749 Darill 841 ss of person who completed cause of death (Item 23a) (Type, Print) endalk AVE AM Bon

Registrar

State

31. Date filed (Month, Day/Year)

2006

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∌egistrar's Signature

			1 - For State Registrer	State of Marylar		ent of Health and I	Mental Hygie	200b	13765
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last ACY 4a. Facility Name (If not institution, give	R	OGER	Sity, Town, or Location of Death	2. Date of Death Month HPRIL	Day Year 29 200 4c. County of Dea	3. Time of Death 6 4648 A M
	Funeral Director	eı	NORTH WEST 5. Social Security Number 6. Se 216-24-7075	HOSPITAL	- R	ANDACCS TO LA	8. Date of Birth (Month, Day, Ye	BALT 9. Bir	thplace (State or Foreign outry)
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	ector	Usual Residence of Decedent 10a. State 10b. County Mary and Balt 10e. Street and Number	more 10c. ci	Reiste	rstown Zip Code	100	Citizen of What Co	10d. Inside City Limits 1 Stres 2 No
_		Funeral Director	25 Bond 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No		2/136 codent of Hispanic Origin? (S pecify Cuban, Mexican, Puert		14. Race - Ame Black, Whit	Prican Indian,
212-0030	within 72 hours after ene. then "naturel", or Ite he Medical Examina	Completed by	3 ⋈ Widowed 4 □ Divorced 15. Decedent's Edi. (Specify only highest grad Elementary/Secondary (0-12)	If Yes, Give Year or Dates:	16a. Decedent's U	work done during most of wor	king 16b	Specify: B	lack Andustry
ylang 21	be filed htal Hyg d othe event,	To Be Con	17. Father's Name (First, Middle, Last) Walker H.	Dawson	L .	18. Mother's Nan Bess	ne (First, Middle, Maidle) ElS	Ned len Sumame)	rsey
тоге, маг	Pages 1 and 2 should ment of Heelth and Mer ant: If Itam 27 le marke ury or other traumatio		19a. Informant's Name/Relationship (T) 20a. Method of Disposition 1 Durial 2 Cremation 3 4 Donation 5 Other (Specify)	Welch 20b. F	19b. Mailing Addr 25 P Place of Disposition (remetery, crematory of the Suntangle)	ess (Street and Number or Ru On A AVE. Name of or other place) ted Meth. 5/6	Reiste	Location - City or	n.Md.21136
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	Physician /Medical		23a. Parl/. Enter the disease, or complete shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		EUMON		or respiratory arrest,		Approximate Interval Between Onset and Death
8700,	cate be executed XX physicien and XX ithe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.					
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ecords, P.	w requires thet the de been signed by the should be detached	Ď	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc		the cause of death?
L Hec	The lay ate has page 2	e Completed	25. Was case referred to medical			26. Place of Dea	24a. Was an autopsy performed 1 Yes 2 X	? prior to death?	utopsy findings available completion of cause of
5	P a th	ation; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Other	ome 5 Residence 28d. Describe how in		ocify)
DIVISION	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specif	fy)		28f. Location (Street City or Town, St	ate)	
	the Hosp in 24 hou the Fune upletely fi	ledical	(Check only 2 Medical Exame	sicien: To the best of my knot iner. On the basis of examina and manner stated.	ation and/or investigat	ion, in my opinion, death occu	rred at the time, date	and place, and due	e to the cause(s)
	0	M	29b. Signature and title of confiler	0	M.D.	29c. License number		PRIL Z	
	,7		30. Name and address of person who or LEUNARD RICHARDSO		m 23a) (Type, Print)	OURT ROAD	0.0000	TOWA) M.	0 21132
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2 2	32. Registrar's Signa	ature Comments	E NORTH	KTANNUCCO	10000 1-11	

			1 - For State Registrar	5	State of	Maryla			nt of H			lental Hy	giene Reg. No.	006	13766
	Physici	an	1. Decedent's Name (First, Mid	dle, Last)								2. Date of De Month	ath Day	Yeer	3. Time of Death
	/Media	cal	Lovely H. 4a. Facility Name (If not institut.		not and num	than)		4b Ca	y, Town, or	Logation	of Dooth	04	21	06 County of Deat	01:40 A M
7	Examir	er		Hospi		iD o i /			ilver				4C.		
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs	. last birthday)		er 1 Year	If Under Hours		8. Date of Bir (Month, Da	th V Year)	Montgo 9. Bin	thplace (State or Foreign
	Director		247-34-8662 Usual Residence of Decedent	1 N	2 F	81	Yrs.	I VIOITUI	Days	110013	141111	01 2			eville, S.C.
	ow ow		10a. State 10b. Coun	ty		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
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93	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Medical Exemi ar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorce		If Yes, Give Year or Da	9		1 🗌 Yes	2 X No	Specify:				Specify: B1a	ck
5	natu	Completed	15. Decede (Specify only high	ent's Educat lest grade c	ion om <i>pleted)</i>		16a. Dece	kind of v	ork done o	turing mos	t of work	ing	16b. Kir	nd of Business/	Industry
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Vlar	Menta Menta arked	To E	Charles R. H	lunter						Jan	nie]	Rice			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exact intermet be collided at ance.		21. Signature of Funeral Service			100						rshall'			
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Division of	or the control of the	Certification:	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	mined	28e. Płace o buildin	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, str ify)	eet, facto	ry, office		1	28f. Location (S City or Tow		Number or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely tilled	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physici al Examiner	an: To the la On the ba	sis of examina	owledge, death ation and/or inv	occurre restigation	d at the tim n, in my op	e, date an inion, dea	d place, a	and due to the ded at the time, of	cause(s) a	and manner as place, and due	stated. to the cause(s)
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	Registr	ar	MAYO	9 2006	(A)		N An	and !	•						

			1 - For State Registrar	State of M	larylan		artment			nd Me		iene	J 0 6	13	767
	Physici		Decedent's Name (First, Middle, Last, Henry Charle;		Jr						2. Date of Dea Month 4		Year 2006		of Death
100	/Medic Examir		4a. Facility Name (If not institution, give North Arundel Ro	street and number)	Ctr			Location of E	Death	. 	4c. Co	ounty of Death nne Aru		- A
	Funeral Director		5. Social Security Number 6. Set 215–18–6176	7. A	ge (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. Min.	B. Date of Birth (Month, Day, 6/7/19	Year)			e or Foreign
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	th with the 23s or 28s	Funeral Director	10e. Street and Number 1146 B Wharf Road	Į.			10f. Zip	Code 1122			1	0g. Citizer	n of What Coun	try?	
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "neturel", or Iteme 23a or 28a-f ehow event, tra Medical Exertifier must be rigitied at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceden Amed Forces 1 ∑ Yes 2 ☐ If Yes, Give Year or Dates:	?		Was Decede f Yes, spec		spanic Origin n, Mexican, F Specify:	n? (Spec Puerto R	ify Yes or No- ican, etc.)		Race - America Black, White, e	etc.	
Maryland 21215-0036	vithin 72 hound.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation	5+)	lite. L	kind of wor DO NOT us	k done d e retired)	uring most of	f working	,	16b. Kind	of Business/Ind		
land 21	ld be filed w ental Hygie ked other ti ic event, Ita	To Be Col	17. Father's Name (First, Middle, Last) Henry Charles Rus	h Sr.		tr	uck d		18. Mother's		First, Middle, Mabelle	Maiden Su			<u> </u>
, Mary	is 1 and 2 should be filed of Heelth and Mental Hygi Itam 27 le marked other other traumatic event, II	-	19a. Informant's Name/Relationship (Ty, Mrs Brenda Schindl		ter				nd Number o	r Rural		City or To	own, State, Zip	Code)	
Baltimore,	permit. Pages 1 Department of He Important: If Itan any Injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)			lace of Disposementery, crementery, crementery	en Cen	her place 1ete1	-y 5	Da /3/0	4.		ion - City or Tov Burnie		
Ba	Departii Depar Impor any Ir		21. Signature of Fued Service License 23a. Part1. Enter the disease, or compli	_ m	oliao d the desti		l Seco	ond A		; G1	len Bur	nie,	eral Hom MD 2106	1	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	e cause on each l	ine.	morar	A	1 4		Lise		751,		Approximation of the control of the	etween
Brou, A	cate be executed SX physicien and SX care ithe burial-transit CX	dicai Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Eue to (or as	a consequ	uanca of):						•			
O. Box 6	death certifi e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spe					23d	Date of deliver	y Day	Year
coras, r	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions con	tributing to death t	out not resu	ulting in the un	derlying ca	use giver	n in Part I.			acco use	contribute to the		death? JUnknown
Ě	The fa ate has page 2	Completed	00							_	24a. Was an autopsy perform	ed?	4b. Were autop prior to com death? 1 \(\text{Yes} \) 2	sy findings pletion of 2 \(\text{No} \)	s available cause of
ion or vital	nding Physician: tth. r: After this certific e funeral director,	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1	iry	EP/Outpatient 28b. Time of Injury		c. Injury	4 Nursir	ng Home	Check only one 5 Reside d. Describe hor	nce 6 🗀	Other (Specify)		
DIVISION	To the Hospital or Atlanding Ph within 24 hours after death. To the Edward Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ury - At ho c. (Specify	me, farm, stre	et, factory,	office		28	Location (Str City or Town,	eet and N State)	umber or Rural	Route Nur	mber,
	the Hosp thin 24 hour the Fune mpletely fil	Medicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best er: On the basis of and manner st	f examinat	wledge, death ion and/or inv	estigation, i	n my opi	nion, death c	lace, and	at the time, da	te and pla	ce, and due to t	he cause((s)
)		_	29b. Signature and title of certifier 30. Name and address of person who cor	y MO	loath //	220) 75:	I	License	1521		ſ	nay	gned (Month, D	06	
	う Sta	10	31. Date filed (Month, Day, Year)		01	en Bus					Brive	20	tt 208		
	Registr		MAY 0 2 2006	Registr	, 1	A									

			1 - For State Registrar	State of Ma	ırylan		rtment tificate			Mental Hy	giene Reg. No.	196	13768
	Physici /Medio		Decedent's Name (First, Middle, Las	Eleane	ra	5	Chu	iar	tさ	2. Date of De Month	Day		3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution, give 5980 Turnabot 5. Social Security Number 6. Se	ct Lane	'A ₁	rs Farm Rd p+ 1 ast birthday)	If Under	Co 1 Year	Location of De Lombio If Under 24 H	rs. 8. Date of Bi	rth	County of Death Howa 9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	□ M 2 X F	87	Yrs.	Months	Days	Hours Mi	n. August		8 Mai	ry land
	ne Maryla 8a-f ehov	Director	Maryland Howar	-d	10c. City	r, Town or Loc	olumb						10d. Inside City Limits 1. Yes 2 □ No
	23a or 2	rai Dire	10e. Street and Number 5980 Turnabout	+ Lane Ho	rpers Ap	Farm Rd +.1	10f. Zip	Code	i		-	zen of What Cou	intry?
980	ours after death with the Marylar ral', or Itama 23a or 28a-f ehow Exandrar must be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Movidowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ★ N If Yes, Give Year or Dates:		11	Vas Decedi Yes, spec	rfy Cubar	spanic Origin? n, Mexican, Pu Specity:	(Specify Yes or No arto Rican, etc.)		4. Race - Ameri Black, White Specify: WF	, etc.
Maryland 21215-0036	o filed within 72 hours after death with the Maryland Hygiene. other then "natural", or Itama 23a or 28a-1 ehow other then "natural", or Itama 2a or 28a-1 ehow fent, tra Medical Examinational be rediffed at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		+)		kind of wor OO NOT us	k doné d e retired)	tion uring most of w	vorking		oun f	
yland	ba la ba	To Be C	17. Father's Name (First, Middle, Last) Carl Til	lman					EII		nKno	wn	
	s 1 and 2 should of Health and Mer Item 27 Is marks other traumatic		19a. Informant's Name/Relationship (7 Pat Sirbaugh / 20a. Method of Disposition	ypo, Print) Daughter	20h PI	19b. Mailin 5980 7 lace of Dispos	Turnal	bout	Lane i	Rural Route Numb Harpers Fan Date	m Rol	Apt, 1 Co	21044
Baltimore,	Pages nent of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ★ Donation 5 ☐ Other (Specify)	CE	ometery, crem	ts Reg	her place gi'str	y April	126,2006	Hand		
Bal	permit. Departr Import eny inj		21. Signature of Euneral Service Licens	588						natomy Gift Suite P. 1	_		21076
\$ 13. 	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Cereby Due to (or as a	θ.	,		,		ac or respiratory a			Approximate Interval Between Onset and Death
8760,	rate be executed by yesician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b									
O. Box 6	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐Fetat	death 3 🗌	Ectopic pre Other (spe				2	3d. Date of deliv Month	ery Day Year
D	sign d be	by	Part II. Other significant conditions co	ontributing to death bu	t not resu	Ilting in the un	derlying ca	iuse give	n in Part I.		obacco us		the cause of death?
of Vital Records,	The law ate has b page 2 sl	Completed	arthritis							24a. Was auto perio 1 \(\text{Yes}		24b. Were auto prior to co death? 1 \subseteq Yes	opsy findings available ompletion of cause of
ion of Vita	ding Phys h. After this funeral di	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)											
Division	al or Attendi s after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At hoi (Specify	me, farm, stre	et, factory,	office		28f. Location (City or To	Street and wn, State)	Number or Rur	al Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funaral Director: completely filled in by the	ledical C	29a. Certifier (Check only one) Certifying Phyone) Certifying Phyone	rsicien: To the best of iner: On the basis of and manner stat	examinati	wledge, death ion and/or inv	occurred a estigation,	it the time	e, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) a	and manner as s place, and due t	stated. o the cause(s)
)	To the H within 24 To the Fi	Me	29b. Signature and title of certifier	A.	n	n.D.		License		3 1	29d. Date	signed (Month,	Day, Year) 2006
4	1'		30. Name and address of person who co			23a) (Type, F Hicker	Print)	ida	e Rd	, Colu	m bic	1, mD	2006 21044
70	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2 20	32 Registra			and of	-)	, , ,	, , , , , , ,			,

			State of Maryland / Department of He	ealth and Me	-	_	13769
			1- Stata Registrar Certificate of D			g.No.U U U	10102
П	Physicia	an	1. Decedent's Name (First, Middle, Last) RUTH K STEVENS	1	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al -	4. City Town and	Location of Death	1400	29 700(7
	Examin	er	Charlestown Retirement Center Catonsv			Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8. Date of Birth (Month, Day,		hplace (State or Foreign untry)
i.	Director		219-10-8907 1□ M 2 X € 81 Yrs. Months Days		Feb. 24	, 1925 MD	
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	aryła shov	5					1 ☐ Yes 2 🛣 No
	the Λ 28a-4	rect	MD Baltimore Catonsville		10	Og. Citizen of What Co	untry?
	3a or		715 Maiden Choice Ln. 21228			USA	
	death ms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of His It Yes, specify Cuban	spanic Origin? (Spec	cify Yes or No-	14. Race - Ame Black, White	
စ္	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Modical Examirer must be mulffled at	/Fu	1 Never Married 2 Married 1 Yes 2 No	Specify:		Specify:	e, etc.
8	urel',	d by	3 X Aldowed 4 Divolced Lear of Dates:	whi		wn	ite
7	"nat	Completed	15. Decedent's Education 16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	uring most of working	g	16b, Kind of Business/	industry
7	withi iene. r than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker			Home	
פַ	il Hygid other	Be C		18. Mother's Name	(First, Middle, M	faiden Sumame)	
Maryland 21215-0036	should be and Mental marked c	To E		Gladys	Reinho	1d	
an	2 sho and I		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	nd Number or Rural	Route Number,	City or Town, State, Z	čip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, it e Medical Examiner must be notified at once.		Paul D. Stevens Sr Son 7830 Edmunds W.			yland 2107	
Baltimore,	iges in of H		1 ☐ Burial 2 1 ☐ Cremation 3 ☐ Removal from State	9)			
弄	permit. Pages 'Department of H Importent: If ite eny injury or ot		'4 □Donation 5 □Other (Specify) Metro Crematory 21. Signature of Funeral Service decease 22. Name and Address	May 1	, 06 B	altimore,	Maryland
Ba	permi Depa Impo eny i		21. Signature of Funeral Service Accessee 22. Name and Address Cremation 299 Frederi	Society o	ot Maryl Catonsvi	and, Inc. 11e. MD 21	228
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition Chronic Obs)/ Chie	Palmonera	Dis	1921	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				
	Examiner	L	Sequentially list conditions, b.				
1	ped isi	Jine	Sequentially list conditions, in any leading to introduce cause. Enter Undertying Cause (Disease or injury				*
I	be execut ician and burial-trar	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
760	te be executed ysician and e burial-transit	caiE					
89	tificat og phy as th	edi					
Вох	The law requires that the death certificate be execution by the attending physician and vage 2 should be detached for use as the burial-trans.	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of del	ivery Day Year
0	e dea the at	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 2 □ No 9 □ Unknown			Worth	ouy ou
<u>Ч</u>	hat th od by detach			n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds,	v requires tha been signed I should be det	d by			1	es 2□No 3□Pr	obabiy A Unknown
Vital Records	w requ	Completed			24a. Was ar	n 24b. Were au	itopsy findings available
Re	The law ate has page 2:	dwo			autops perform	y prior to o ned? death? No 1 ☐ Yes	completion of cause of
ital		0	25. Was case referred to medical	26. Place of Death		4.10	20110
	S S D	To B	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other	r: Nursing Hom	ne 5 🗆 Reside	nce 6 □Other (Spec	cify)
n o	ng Ph Ifter th Ineral			.?	8d. Describe ho	w injury occurred	
sio	Attending r death.	cati	2 Accident investigation M 1 Y	res 2 □No	10f Location /St	reet and Number or Ru	ural Pauta Number
Division of	i Dir	Certification:	3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	City or Town		irar noute reutiber,
_	Hospitel 24 hours a Funeral I			e, date and place, a	nd due to the ca	ause(s) and manner as	stated.
	e Hoo	edicai	(Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opi and manner stated.	inion, death occurre	ed at the time, da	ate and place, and due	to the cause(s)
	To the within 2 To the complet	Me	₹ 29b. Signature and title of certifier 29c. License			9d. Date signed (Monti	
	ì		M M D474	14 1		April 30, 2	al
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6 (atus	150:16	April 30, 20	
	7		V .			¥	
	Sta Regista		MAVA				
74			A STATE OF THE STA				

			for State Registrar	State of N	laryland /		artment of F		nd Mer		ne 0 0 6	13770
. ģ	Physici	an	1. Decedent's Name (First, Middle,	Last)						Date of Death Month	Day Yea	3. Time of Death
	Physici /Medio			Ruth Swiny					A		9, 2006	8:25 A M
	Examín	er	4a. Facility Name (If not institution,)		7)		4b. City, Town, o				4c. County of De	
	Funeral	48		. Sex 7. A	ge (In yrs. last	birthday)	Havre If Under 1 Year	If Under 2	ACE 14 Hrs. 8.	Date of Birth (Month, Day,)	Harfo	org irthplace (State or Foreign Country)
П	Director		008-14-8595	1 □ M 2 💆 F	84	Yrs.	Months Days	Hours	Min.	$\frac{1}{1}$ UN 2, 19	921 Ma	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	ocation					10d. Inside City Limits
	Maryli f sho	ō	Maryland Harfor	-d			Havre D	e Grad	ce			1 ☐ Yes 2 No
	r 28a	Directo	10e. Street and Number				10f. Zip Code			100	J. Citizen of What (Country?
	th with		61 Robin Hood	Road			21	.078			USA	
	r dea	Funerai	11. Marital Status	12. Was Deceder Armed Forces	?	13.	Was Decedent of H	lispanic Orig an, Mexican,	in? (Specify Puerto Rice	Yes or No- an, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 If Yes, Give Year or Dates] N o		1□ Yes 2∑No	Specify:			Specify: T	√hite
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or items 23e or 28e-f show Le Medical Everniner most be notified at	ed	15. Decedent's	Education		Sa. Dece	dent's Usual Occup	ation		16	Sb. Kind of Busines	
215	d within 72 ho giene. In then "natu	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	5+)	(Give life.	kind of work done DO NOT use retired	during most d)	of working			
N		Son	12			Pho	otographe				U.S. Ar	my
	e ta e	Be	17. Father's Name (First, Middle, La	ist)					"s Name <i>(F.</i> my Mar		uiden Sumame)	
7	should I	P	Arthur James 19a. Informant's Name/Relationship	(Type, Print)	1	- 9b. Maili	ng Address (Street				City or Town State	Zin Code)
Z Z	2 2 2 2		Beulah Harris/				Thompson				-	
Je,	s 1 and 3 Health item 27 other tr		20a. Method of Disposition		20b. Place		osition (Name of matory or other place		Date		c. Location - City	
imo	nit. Pages eartment of f ortant: If its injury or of		1 ☐ Burial 2 ② Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				matory,		5/1/06		Baltimo	,
Baltimore,	permit. Pages Department of Important: If I eny injury or once.		21. Signatura Funeral Service Li	centere L			2. Name and Addre					of MD, Inc.
	00 = 0		W//L X	9 MWW	ngu		299 Frede					ZTZZ8 Approximate
	* \$		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	toe.	7 -		1				Interval Between
3.	Physician /Medical		disease or condition resulting in death)	a. TUN	YO ECU	erol	re lev	raiso	vasin	ulay	diseas	<
W.	Examiner			Rom	al .	fa	luna					
1	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	of):		1				
×	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Core	s a consequence	1	Ortery	do	zen	se		
760,	te be executed ysicien and le burial-transit	calE		240 (01 0	3 a consequent		U					
	9 × 6		119	d								
Вох	death certificat e attending phy od for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal dea	th 3	Ectopic pregnancy	,			23d. Date of d	elivery
B.	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		Other (specify)				Month	Day Year
P.0	that the de ed by the detached		9 Unknown Part II. Other significant condition		but not recultion	in the u	ndorhing course gu	en in Dort I		23a Did toba	cco use contribute	to the cause of death?
ds,	sign d be	d by	raitii. Ottor significant condition	s contributing to death	Dat not resulting	y 111 (11 0 0	ilderlying cause giv	enin raici.				Probably 4 □Unknown
Record	w requ been shoul	Completed								24a. Was an	24h Were	autopsy findings available
Be	: The law cate has	dmo								autopsy performe	prior to death?	completion of cause of
		a a	25. Was case referred to medical					26. Place	of Death (C	1 ☐ Yes 2 ☐	No 1□Ye	es 2 No
>	d is	To B	examiner? 1 ☐ Yes 2 ☑ No		tient 2 ER/	Outpatie	nt 3 DOA Cth	er: 4 □ Nur	sing Home	5 nesiden	ce 6 □Other (Sp	pecify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28t Jay Year)	. Time o Injury	Wor			. Describe how	injury occurred	
Division	r Attendi er death. rector: A by the fu	icat	2 Accident Investiga 3 Suicide 6 Could no	t be 390 Place of I	niuny - At homo	farm et	M 1 □	Yes 2□N		Location (Stre	et and Number or	Rural Route Number.
	after death after death Director: d in by the	Certification;	4 Homicide determin	building,	atc. (Specify)	ium, st	cot, factory, office			City or Town,		Talas Trodio Trassoci,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the bestaminar: On the basis	at of my knowled	lge, deat	h occurred at the tir	me, date and	place, and	due to the cau	se(s) and manner	as stated.
	the Hin 24 the Find Philadele	Medical	one)	and manner	stated.	andvorin			n occurred a			
	To the comple	2	29b. Signature and title of certifier	11 1)		29c. Licens	se number	11		I. Date signed (Mo	
	1		20 He	e /VIII	doub (les- co	a) /T	Print)	106	01	Ma	ay 1, 200	<i>J</i> b
	6		30 Name and address of person w	o completed cause of	691	(Type,	Outron	1 54	1- 14	auro	do €	Frace
	Sta		31. Date filed (Month, Day, Year)	32 Pegis	trar's Signature		the low		111		UD -	21078
	Registi	rar	MAY 0 2	2006	w. It		well -			· · · · · · · · · · · · · · · · · · ·	V-	

06-02816 Gloria Shapiro

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Gloria Lundy Schapiro **Medical Examiner** 0636 hrs April 26, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatl 4c. County of Death 3900 North Charles Street, Apt. 1102 Baltimore Funeral Social Security Number 6 Sex 7. Age (In yrs, last birthday If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or Min. South Hours March 4,1940 Director 247-56-0547 1 M 2 F Carolina Yrs Usual Residence of Decedent Inv 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore or 28a-f show X Yes 2 No notified at once. after death with the Maryland Director 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? 3900 North Charles Street 21218 United States 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 8lack, must be or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes White 3 X Widowed Divorced f Yes. Give Year Yes 2 X No specify: Specify other than "natural", 2 ges 1 and 2 should be filed within 72 hours of Health and Mental Hygiene 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired)

Executive Administrative Morton H. Schapiro C.P.A. Elementary/Secondary (0-12) 21215-0036 Assistant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Fritz Oliver Evelyn Mary Lou Lundy is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 136 Springside Drive, Timonium Maryland, 21093 nt: If item 27 is other traumat Mrs. Joan Batema (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, timore, Date 20c. Location - City or Town, State Pages 1 1 Burial 2 X Cremation 3 crematory or other place) Removal from State Forest Hill, Maryland Department of Important: I Apr. 28, 2006 Evans Funeral Chapel Donation 5 Other Specify: 21 Signature of Funeral Service Licensee

22. Name and Address of Facility

Peaceful Alternatives Funeral & Cremation Ctr.PA.

2325 York Road Timonium, Maryland, 21093

23a Part I. Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ine cause on each line. **Physician** /Medical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of). Examiner (Disease or injury that initiated events resulting in death) Last 4 Due to (or as a consequence of) and Physician/Medical sician a UNPENDED AMENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending phys IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown a Unknown ned by the a signed by t be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed s peen s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed' death? page this certificate 1 🗸 Yes Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medica 26 Place of Death (Check only one) Be examiner? ER/Outpatient 3 Inpatient 2 DOA 1 🗸 Yes Nursing Home 5 Residence 6 ✔ Other: Scene 2 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification Subject jumped from 11th floor apartment Natural FOUND 5 Pending Yes 2 V No Director: d in by the f after death. Apr 26, 2006 0633 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 3900 North Charles St, Apt. 1102, Baltimore, MD within 24 hours at To the Funeral D determined (Specify) Apartment building 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) mos O.C.M.E April 26, 2006 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimpre, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

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Registrar

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	Maryli f sho	tor	Maryland Baltimo	re	Arbu									s 2 No
	h the	Director	10e. Street and Number	-			10f. Zip Code			10g. (Citizen of Wh	at Cour	ntry?	
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36	s within 72 hours after death with the Maryland jiene. rthan "natural", or itema 23a or 28a-f show I're Mudical Examiner must be motified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3√☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		I	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2☐XNo	tispanic Origin? an, Mexican, Put Specify:	(Specify Yes or erto Rican, etc.)	No-	14. Race - Black, Specify:	White,		
9	2 hou	ted	15. Decedent's E	ducation		16a. Deced	ient's Usual Occup	ation	- 75.	16b.	Kind of Busi	ness/Ind	dustry	
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and	Q 22 0 0	To Be	77.11	Sauter							и зитате)			
Maryland	S B E E	ř	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street		rothy D Rural Route Nu		or Town, St	ate, Zip	Code)	
	and 2 is a 27 is er trau		Michelle Green,	daughter		5626	Braxfiel	d Rd. A	rbutus,	MD.	2122	7		
Baltimore,	ges 1 a t of Hee If item or othe		20a. Method of Disposition1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ce of Dispo	sition (Name of natory or other place an Cemete	Ce)	Date	20c.	Location - Ci	ty or To	wn, State	
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			1 - For State Registrar	State of M	larylan		artmer rtificat			and M	ental H	ygien Reg. No	211116		3774
	Physici		Decedent's Name (First, Middle, L Gladys	est) Edna			Spill	.er			2. Date of D Month April		2006 Year		ime of Death
Y. page	/Medi Examir		4a. Facility Name (If not institution, g	ive street and number	r)		4b. City, Town, or Location of Death				4c. County of Death			• 2 1 A	
		. 2	1924 Crafton Aver					indal		0411-0		Baltimore			
ł	Funeral Director		5. Social Security Number 6. 218-48-2469 Usual Residence of Decedent	Sex 1 M 2 F 7. A	78	last birthday) Yrs.	Months		Hours	Min.	8. Date of B (Month, D December	r 7,1		ithplace (Sountry) Limois	State or Foreign
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5-0036	n 72 hours after death with the Maryland "natural", or items 23e or 28e-f ahow calcal Estimiter must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? X No	ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et					cify Yes or N Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
215-0	-	Completed	15. Decedent's E (Specify only highest g	rade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						ng	16b. Kind of Business/Industry			
212	Hygiene. Hygiene. Ither than "	Com	12 years	College (1-4or	5+)		Secre					Но	spital		
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		Physici	an	Decedent's Name (First, Midd	le, Last)						2. Date of D		ay Year	3. Time of Death		
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		Examir	ner	4a. Facility Name (If not institution						r Location of Dea	th	4	c. County of Death			
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		Funeral Director		215–16–1102	1 ☐ M 21X F		90 Yrs.	Months		Hours Min	. (Month, E	iπη ay, Υθα - Э1	7) 9. Birth Cou	place (State or Foreign Intry)		
				Usual Residence of Decedent							August	. 31,	AL CIGIT	abama		
		ehow	_	10a. State 10b. County		10c. (City, Town or L	ocation						10d. Inside City Limits		
		Ba-f	octo	Maryland Harford Belair							1 Tes					
		with ti	Funeral Director	10e. Street and Number 10f. Zip Code								10g. C	Citizen of What Cou	ntry?		
		eath	erai	519 Greenridge Road 21015 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S									USA	and Indian		
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6	ary	should and Men a marke umatic	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address	(Street a				or Town, State, Zij	Code)		
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	Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	6 C. Co	mul	Ley 1	<u> 110 S</u>	отте	rs Poin	Road,	Dung	dalk,P.A. dalk,Md.	21222		
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		/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):		. 1	75) 500	16 +4	7,10	Villa 4.)		
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/	rd	v require been sig should b	edt	Acute	MYDO	andi	à1.7	nota	vet	77)	1 🗆	Yes 2	2 □-M 6 3 □ Prob	ably 4 Unknown		
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		2		30. Name and address of person	who completed caus	of death (Ite	m 23a) (Type,	Print)		PL	Su/St	120	H Xh	endeen.		
	500			31. Date filed (Month, Day, Year)	T - 19	egistrar's Sign		OIP		Mar	yland	(2100)			
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	Examin	er	FUTURECARE NUR		E		IMORE						
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	yland now		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits			
	8e-f st	ctor	MD		BALTIM					1 ☑ Yes 2 □ No			
	with th		10e. Street and Number			10f. Zip Cod		1	0g. Citizen of What Co	ountry?			
	eath v	eral	227 S. WOLFE S	12. Was Decedent E	ver in U.S. 13	2122 Was Decedent	4 of Hispanic Origin? (S Cuban, Mexican, Puert		JSA 14. Race - Ame				
ထ	after d	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	lo	If Yes, specify (o Rican, etc.)	Specify: WH				
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Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1 per doc 9855 5-2-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) Alan Gary Smith 2. Date of Death 3. Time of Death **Physician** Month Year 6:22 AM 2006 /Medical apr 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 113 Main Street Garrett Grantsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days **1**∕ M 2□ F Hours 70 218-32-3946 Yrs. Director Pennsvlvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f shov other traumatic event, the Modical Examiner must be notified at Director Maryland Baltimore Baldwin 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MIT 13602 Brookline Road 21013 LISA or Itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X'es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filad within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No Specify: White 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic auchs. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Civil Engineer State of Marvland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith Helen Mover Myron ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13602 Brookline Road Carolyn Smith / Wife Baldwin, Md. 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp. 5/2/06 Towson, Maryland 21. Signature of Functial Service Licenses 22. Name and Address of Facility 1050 York Road CFS/Ruck Towson Funeral Home, Inc.Towson.Md.21204 23a. Part1. Enter the disease, or complications and shock, or heart failure. List only one cause on disease. at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ten /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ö Month Year Dav 4☐Pregnant at time of death 5 Other (specify) P.0. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed2 Vital 1 ☐ Yes 2 ☐ No 1 Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ٩ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 4 Nursing Home 5 Residence 6 Nother (Specify) Holis this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitel or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel L 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4/41 31. Date filed (Month, Day, Year) 32 Aleistrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 27, Mary 2006 10:10 a^M Shade /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson 7. Age (In yrs. last birthday)

7L Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth North Days Hours Min. North Day 1931 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) 1 □ M 2**X** F 220-24-7464 Director Maryland Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at MD Baltimore Lutherville 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 22 Seminary Drive U.S.A. or Itema 23a filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7/2 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ns any injury or other traumatic event, the Mudis once. Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Treasurer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Billingslea Lillian ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Seminary Dr., Lutherville, MD 21093 Robert C. Shade-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/1/06 St. John Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Hydes, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer -UNG Physician 1ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for se's consequence off The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 nonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Naspia Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1∐ Yes 2∭ No ို After this funeral of Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 Tes 2 No 2 Accident after death Director: the 3 🗌 Suicide 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 58303 APRIL 27 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Pcint)
AAMON Charks un 6601 N. Charks St Briting in Z1204 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20a-c,22,pertH,0855,5/3/06 TT Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Daryl Thompson April 21, 2006 2:50 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton

If Under 1 Year If Under 24 Hrs. |
Months Days Hours Min. Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ₱M 2 ☐ F Months 080-56-9867 Yrs Aug 31, New York 1961 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Steuart Lane Funerai 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Thompson Shirley Kirnon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Thompson/father 7781 Coral Colony Way J.ckeworth, FI 33457 e of Disposition (Name of Date 20c. Location - City of Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ②Other (Specify) in state Pineview Cemetery 5/6/2006 Durfield Beach, FL 21. Signa ure of Funcial Service Licensee 22. Name and Address of Facility March F. H. Fast 1101 Fast North Avenue Ronald State Anatomy Baltimore Street Baltimore, MD 21201 21202 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 death.

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Exercities must be notified at

the Maryland

death with

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other traumatic avant, the Mudical Experiment once. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner burial-transit attending physician and for use as the burial-trar Physician/Medicai be detached signed by the <u>م</u> Completed the Hospital or Attending Physician: Be 1 Impatient 2 this After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of confiler completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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			Registrar	-41	Сеппса	te of Death	2. Date of Death	ı. No.	3. Time of Death
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S. Salah	Funeral Director		5. Social Security Number 6. S 214-18-2114	ex 7. Age (In yrs.	/ast birthday) If Under Months	or 1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth (Month, Day, Y	1912 9. Bi	rthplace (State or Foreign ountry) MARY AND
	pu >		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Location		,,,,,,		10d. Inside City Limits
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	the Marylan 28a-f show	ect	10e. Street and Number	219	LIMORE	p Code	100	g. Citizen of What C	ountry?
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anc	ntal h	Be	PREDI TODA	IEU		ANNIE		Z	
Maryland	should be nd Mental marked c	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addres	is (Street and Number or Ri		City or Town, State.	Zip Code)
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ຄົ	s 1 ar f Hea item othe		20a. Method of Disposition		Place of Disposition (Na emetery, crematory or	other place)	Date 20	oc. Location - City o	Town, State
Ę	Page nent o int: If iry or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Hemoval from State	INITY	5/2	-106 B	4150. M	Ď,
Baltimore,	permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tra <u>once</u> .		21. Signature of Pineral Service Licer			and Address of Facility	HILLIP A.W	EMHERFO	RD FIS.
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	Physician		23a. Part 1. Enter the disease, or com shock, or he tailure. List only Immediate Cause (Final disease or condition	plications that caused the deat one cause on each line.	h. Do not enter the mo	de of dying, such as cardia	c or respiratory arres	it,	Approximate Interval Between Onset and Death
7	/Medical Examiner		resulting in death)						
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D. Box	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 □Ectopic i		23d. Date of delivery Month Day Year		
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ta	ian: rtifica ttor, p	0	25. Was case referred to medical			26. Pface of De	ath (Check only one)		
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Division of Vital Records,	s after of all Directed in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, St.						Rura! Houte Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		nysicien: To the best of my knominer: On the basis of examina and manner stated.					
	To the Within To the	Me	29b. Signature and title of sertifier			9c. License number		d. Date signed (Mor	
			must 1	ND		RES-000		04,27,	2006
-	3		30. Name and address of person who						
			NIHARIKA DIXIT, 4	SON SAMAKITAN	MUSPITAL, SE	01, LOUY RAU	EN BLUD.	BALTIMOR	t, MD-21239
A	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture				

		•	State of Marylan	d / Depa	artment of Hertificate of L	ealth and l	Mental Hy	giene	6	13782				
			Decedent's Name (First, Middle, Last)				2. Date of De		V	3. Time of Death				
	Physici: /Medic		Lucille J. Thorne				Month O4	Day 24	Year 06	5:51A M				
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	h	4c. County	of Death					
			Washington Adventist Hospital		Takoma				gomer					
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 82 82	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da 02 28	th ly, Year) 3 24	9. Birthpi Coun Nash	ace (State or Foreign try) Co. N.C.				
	death with the Maryland ims 23e or 28e-f show it must be notified at	'n		y, Town or Lo					11	0d. Inside City Limits 1 X Yes 2 □ No				
	the N	Director	MD Prince Georges Mt 10e. Street and Number	. Rai	10f. Zip Code			10g. Citizen of	What Coun	trv?				
	with	Ö	3001 Shepherd Street		20712			USA		,.				
	leath	era	11. Marital Status 12. Was Decedent Ever in U.	.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S	pecify Yes or No		ce - Americ	an Indian,				
21215-0036	be filed within 72 hours after death with the Marylan Ital Hyglene. It other than "natural", or liems 23e or 28e-f show event. It a Michael Examinat must be nutified at	by Funerai	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	Specify:		Black, White, etc. Specify: Black						
รุ	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion	diaa	16b. Kind of B	usiness/Inc	lustry				
מ	within 72 ane. then "nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done d DD NOT use retired)	uring most of woi	rking							
Z	od wit	Con	Elementary/Secondary (0-12) College (1-4or 5+)	C1	Lerk					unications				
0	be filed hat Hygie d other	Be (17. Father's Name (First, Middle, Last)					le, Maiden Sumame)						
yland		ဂ္	Sam C. Jones			e Foster								
<u>a</u>	s 1 and 2 should if Health and Mer item 27 te marke other treumetic		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a					Code)				
as a	item 27 other tr		Glandus M. Thorne/Son		Shepherd	St. Mt.	Rainier	MD. 2		State				
Ö	f of F		1 □ Burial 2 □ Cremation 3 □ Removal from State	emetery, cre	matory or other place									
Baltimore,	t. Pa rtmen rtent: njury		4 Donation 3 Dones (opouny)		coln Cem.			Brentwo	-					
e C	permit. Pages 1 Depirtment of H Importent: If ite any injury or ott	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011												
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	/Medical		resulting in death) a. Due to (or as a conseq						- 5					
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,	Sit ad	Examiner	Sequentially list conditions, if any, leading to immediate states. Either through the states are the states and the states are											
/	and and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq	uence of):										
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289	phys phys the	_	d											
ROX	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? in the past 12 months? ↓ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Ideath 3[□Ectopic pregnancy □ Other (specify)				ite of delive	ry Day Year				
o.	at the de by the a tached f	nysi	1 🕱 Yes 2 🗆 No 9 🗍 Unknown 9 🗍 Unknown											
Records, P	as tha	by	Part II. Other significant conditions contributing to death but not resultable Diabetes Mellitus	ulting in the u	nderlying cause give	n in Part I.		obacco use con Yes 2½ No		e cause of death?				
Ö	w require been sign	iete	Hypertension				24a. Was	an 24b.	Were autor	osy findings available				
ě Y	The law ate has page 2	Completed						psy ormed?	prior to cor death?	npletion of cause of 2 No				
		e C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes ath (Check only		I LLI TES	2 100				
	S S	0	examiner?	ER/Outpatie	nt 3 DOA Othe	-	lome 5 ☐ Resi		ner (Specify	′)				
	De Te	tion: T	27. Manner of Death 1 That natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time o Injury	Work	at ? ∕es 2 □ No	28d. Describe	how injury occur	rred					
Division	or Attendiater death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Specification)	ome, farm, st	reet, factory, office		28f. Location (City or To	Street and Numl wn, State)	ber or Rura	l Route Number,				
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred at the time evestigation, in my op	e, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)				
	To th Within To th	Me	29b. Signature and title of certifier	Λ	29c. License	number		29d. Date signe	ed (Month, i	Day, Year)				
	,		Kama (Cliff	4	D196	09		04-24-	-06					
	1		30. Name and address of person who completed cause of death (Item	n 23a) (Type,		·								
_	2		Raman R. Tuli, MD. 10810 Darne	stown	Road Suit	e 202 Ga	ithersb	urg, MD.	2087	78				
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 2 2006 32. Registrar's Signa	iture	(ach)									

			1 - State Amend item#5, perF	State of Ma H,G857,7/25	ryland /06 TT	/ Depa	rtment of tificate of				giene	6	13783
	- · · ·		1. Decedent's Name (First, Middle, Last)							2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio	dical Katherine wood Haynes Troth								April	29, 20		1:50 A M
	Examin			Facility Name (If not institution, give street and number) 4b. City, Town, or Locat							4c. County		
									Rockville			tgom	
ł	Funeral Director		273 -22-2804	M 2 X F	84	Yrs.	If Under 1 Ye Months Da		ler 24 Hrs. s Min.	8. Date of Birt (Month, Da May 26	y, Year) , 1921		place (State or Foreign ntry) ntucky
	and II		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					1	10d. Inside City Limits
	Mary f ehd	ō	Maryland Montgome	rv	Bet1	hesda							1 ☐ Yes 2X No
	r 28a	Directo	10e. Street and Number				10f. Zip Cod	е			10g. Citizen of W	/hat Cour	ntry?
	23a o 23a o	a D	5707 Lone Oak Dri	ve			20814					d St	ates
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show emprivatury or other traumatic event. The Medical Examinar must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 1	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N		1				cify Yes or No Rican, etc.)	s or No- etc.) 14. Race - American Indian, Black, White, etc.		
200	2 hours atural, cal Exar	ted by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Educ	If Yes, Give Year or Dates:	- 35	16a. Decede	□ Yes 2 X t	cupation			Specify: White 16b. Kind of Business/Industry		
7 7 1 7	l within 7 liene. r than "n the Med	Completed	(Specify only highest grade	College (1-4or 5-	+)	(Give kind of work done during most of working life. DO NOT use retired) Homemaker					Own Home		
2	e file othe vent,	Bec	17. Father's Name (First, Middle, Last)		·			18. Mo	ther's Name	(First, Middle,	Maiden Sumam	ө)	
<u>a</u>	uld by Menta Irked Itic e	ToE	Warner E. Haynes					F	rances	s Wood			
<u></u>	and I		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailing	g Address (Stre	eet and Nun	nber or Rura	i Route Numbe	ar, City or Town,	State, Zip	Code)
ž.	and eelth m 27	1	Edwin Troth / Son		Jan						a, Maryl		20814
2	ages 1 ant of H t: if ite y or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	сел	netery, crem Mont	ition (Name of atory or other p gomery	olace)	May		20c. Location -		
	Departme Departme Importan eny injur		21. Signature of Funeral Service License	9	C		orium, Name and Ad Dert A.		200 cility Ev Fune:				Maryland Chase, Inc.
	40 E 9 9		23a. Part1. Enter the disease, or complic	MO1	the death.		o/ Wisco	nsin At	zenue, 1	Bethesda.	, Maryland	208	14 Approximate
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Myocar	dial		ction						Interval Between Onset and Death
	Examiner		•	Due to (or as a									
		ē	Sequentially list conditions, if any, leading to immediate	Atrial			Lon					+	
	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Ischem	ic Le	ft Lov	ver Ext	remit	У				
5	icate be executed physicien and s the burial-transit	E EX	resulting in death) Last	Due to (or as a	conseque	nce of):							
0	physicate to the table the table the table the table t	dicai	d.									-	
. DOA .	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date 1 □ Yes 2 ☒ No 9 □ Unknown 4 □ Pregnant at time of death 5 □ Other (specify) □ Mor									of delivery n Day Year	
	that thed by		Part II. Other significant conditions conf	ributing to death bu	t not resulti	ing in the un	derlying cause	given in Pa	rt I.	23e. Did to	obacco use contr	ibute to th	ne cause of death?
5	requires een sign rould be	ted by									∕es 2XINo	3 🗌 Prob	ably 4 🗀 Unknown
200	The faw ste has b page 2 sh	Completed								24a. Was autop perfor 1 Yes	rmed? d	Vere auto rior to cor eath? Yes	psy findings available mpletion of cause of
2	ilan: artifice ctor, p	Be C	25. Was case referred to medical examiner?	10-100				26. Pla	ace of Death	(Check only o	21		
>	hysic his ce I dire	P	1 ☐ Yes 2 X No	spital: 1 Inpatien		VOutpatient	3 DOA		Nursing Hom	ne 5 ☐ Resid	ience 6 💢 Othe	r (Specif) Hospice
	anding P eth. rr: After t ne funera	atlon;	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28	8b. Time of Injury		njury at Vork? Yes 2		8d. Describe h	now injury occurre	ed	
2	at or Atte s after de il Directo d in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	ry - At hom . (Specify)	e, farm, stre	et, factory, offic	C 0	28f. Location (Street and Number or Rural Route Number, City or Town, State)			l Route Number,	
	Mospit 24 hour Funera letely fills	Medical C	29a. Certifier (Check only one) 1	cian: To the best of er: On the basis of and manner stat	examınatıcı	edge, death n and/or inve	occurred at the	e time, date ly opinion, d	and place, a leath occurre	and due to the o	cause(s) and mai date and place, a	nner as si and due to	ated. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier				29c. Lice	ense numbe	or		29d. Date signed	(Month,	Day, Year)
					M)	D	35635			May 1	, 20	06
	ih		30. Name and address of person who cor	npleted cause of de	ath (Item 2	3a) (Type, P	rint)		· · · · · · · · ·				
	10		Joseph Kaplan, M.				Mil1 :	Road,	Rock	ville,	Marylan	d 20	0855
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2 200	32 Registra	r's Signatur	· Ago	Nes .						

06-02827 Kimberly Unglesbee

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Kimberlv Grace Unglesbee Month Day April 26, 2006 Medical Examiner 1412 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year **Funeral** Days Director 219-25-3465 Months Hours oreign 1__M 2 X F 2.1 03 - 18 - 1985Country) MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits MD Baltimore Owings Mills 28a-f show 1 Yes 2 X No after death with the Maryland Director s 23a or 28a-f e notified at o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? #3H Trolod Court 21117 USA Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, must be Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. Yes Specify: white If Yes. Give Yea Widowed Divorced Yes 2 X No specify: à ges 1 and 2 should be filed within 72 hours it of Health and Mental Hygiene

If item 27 is marked other than "natura ther traumatic event, the Medical Examii 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 cashier food service 12 17. Father's Name (First, Middle, Last)
Claude Unglesbee 18.Mother's Name (First, Middle, Maiden Surname) Bonnie Mays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3H Trolod Ct., Owings Mills, Md 21117 Bonnie Unglesbee (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State permit Pages I a
Department of He
Important: If it 1 Burial 2 X Cremation 3 Removal from State crematory or other place) All County Cremation 05-01-06 Sykesville, Md Donation 5 Other Specify ë Signature of Funeral Service Licenses 22 Name and Address of Facility Haight Funeral Home & Chapel Large Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical Death Narcotic (Mornhine) intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated 16 Due to (or as a consequence of) events resulting in death). Last res that the death certificate be executed and Physician/Medical item#23a,PII,27,28a-f,perME,g855,5/12/06 TT X UNPENDED AMENDED Sician Box 68760, IF FEMALE phy: the b 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Cocaine use Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 1 🗸 Yes 2 No. To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26 Place of Death (Check only one) 1 / Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Pending 1 Yes 2XX No 24 hours after death Funeral Director: the Fnd 4/25/2006 unk Investigation Accident in by 28f. Location (Street and Number or Rural Route Number, City or Town, State). Corner of Wilkens Ave. and Monroe Street, Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide Found city street (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E April 27, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Susan Hogan MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

State Registrar 100

32 Registrar's Signature

Hagothman

2006

Ahmod W. 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 10:40 AM Norma Jean VanDivner April 28, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3905 Blooming Rose Rd. Friendsville Garrett If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 216-34-7968 7. Age (In yrs. last birthday). 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □XF Director Sept. 4, 1935 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at Maryland Garrett Friendsville 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3905 Blooming Rose Rd. 21531 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White ⋛ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked otherny injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Fazenbaker Mary House 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald VanDivner, 3905 Blooming Rose Rd. Friendsville, MD. husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory May 1, 2006 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. eller ft 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dia to (or as a consequinc) of): Physician adonoCA ZURERS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificete be executed Due to (or as a consequence of) ed by the ettending physician detached for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed Pary II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 2 Pesidence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) Director: After the 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier di 10 garrett highway oakland, Me 30. Name and address of completed callse of death (Item 23a) (Type, Print) Margares

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

32 Registrar's Signature

(Month, Day, Year)

MAY 0 2 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) month r 19, Physician 2:40 p 2006 Apr Albert White /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Clinton Southern Maryland Hospital Il Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours 1⊠M 2□F Yrs. 60 Director 578-60-1220 July 7, 1945 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Pages 1 end 2 should be filed within 72 hours after death with the Maryla ment of Heatih and Mental Hygiene. and the Heatih and Mental Hygiene ant: if item 27 is marked other than "natural", or items 23a or 28a-1 show ury or other traumatic event, it a Medical Examinat must be notified at 1 Yes 2X No Director MD Prince Georges Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9211 Stuart Lane 20735 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unk unk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Southern Maryland Hospital 7503 Surratts Road Clinton, ND 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: if any injury or once. 4 □Donation 5 ☒Other (Specify) in state 21. Signature of Euneral Service Licensee Ronald 8. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 errer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Disth Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 Whitnown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificete has autopsy 2□ No 1 Yes 2. No 1 ☐ Yes Hospitel or Attending Physician: After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 atient 1 Yes 20 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending To the Hospitel or Attending within 24 hours effect death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

2 2006

31. Date filed (Month, Day, Year)

30. Name and addre

(Check only one)

29b. Signature and title

Registrar's Signature

and manner stated

s ol person who completed cause of death (Item 23a) (Type, Print)

VIVINGSTUN

29c. License number

29d. Date signed (Month, Day, Year)

06-02901

Please Type or Print in Black Indelible Ink

obert wiggins		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar) (
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day April 29, 2006 3. Time of Death 2300 hrs	
and the second s		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3808 Erdman Avenue 4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9/Birthplace (State or Foreign Country) North Days Hours Min. Aug. 13, 1952 Country) Md.	
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limit	ıts
Maryland 28a-f show d at once.	Director	Md Balt more 1 Xyes 2 In 10e. Street and Number 2nd 10f. Zip Code 10g Citizen of What Country?	V O
ith the Maryland 23a or 28a-f sho notified at once		3808 Erdman Ave, Floor 2/2/3 USA	
ifter death w	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Property of Pates: 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, White, etc. 15. Yes 2 No specify: Specif	
136 hin 72 hours a e. than "naturs sdieal Exami	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	
Baltimore, MD 21215-0036 permit Pages I and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once	8	17. Father's Name (First, Middle, Last) Robert Wiggins Sr. 18. Mother's Name (First, Middle, Maiden Surname) Ursula Brown	
MD 2 td 2 shoul lith and M m 27 is m aumatic	P	19a Informant's Name/Relationship (Type rolling aughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MS, Ra Shonda Wiggins 16000 Park Heights Ave. HIA Bulto, Md, 212	15
Baltimore, permit. Pages I an Department of Hea Important: If iter		20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/5/2006 Batto Md.	
Balti permit. Departr Import injury		21 Signature of Funeral Service Licenses 22. Name and Address of Eacility Joseph L., Russ Fyneral Home, P. A. 12222 W. North Ave Balto. Md. 2 (216)	
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> કહ્યું ≒ા	Certification:	Suicide Could not be determined (Specify) Found Residence or Town, State) 3808 Endman Avenue Baltimore City, MD	ty
Di To the Hospital within 24 hours a To the Funeral	Medical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated one)	
F × F 3	Me	29b. Signature and futle of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 30, 2006	
		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Si Regis	ate trar	\$1.0\/ a 0 0000 100a NV AF atta-05 P	
		V: Triangle of the control of the co	

		For State	State of Marylan	d / Depa	artmer	nt of Hea	alth and	1		nnc	19790
		1 - State Registrar		Ce	rtificat	te of De	eatn	2. Date of De	Reg. Ne.	000	1010J
Physic	ian	1. Decedent's Name (First, Middle, Last)						April	21,	2006	3. Time of Death 9:40P M
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Exami	ilei	Genesis Elderca		Ln		timor			A	nne Ar	undel
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.			r 1 Year If	Under 24 Hrs lours Min.	(Month, Da	th y, Year)		nplace (State or Foreign untry)
Director		234 28 8836 Usual Residence of Decedent	81	770.				5/10/	192	4 Wes	t Virgini
nyland show	_	10a. State 10b. County	10c. City	, Town or Lo	ocation						10d. Inside City Limits
the Ma	Director	MD Anne Ar	undel Pas	adena		p Code			10g Citi	zen of What Cor	1 ☐ Yes 2 MNo
3a or	Di	713 208TH	St.		101. 21		1122			U.S.A.	
death	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dece	dent of Hispa	nic Origin? (S	Specify Yes or No to Rican, etc.))-	14. Race - Amer Black, White	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, ir a Medical Examinating must be notified at any injury or other traumatic event, ir a Medical Examinating must be notified at any once.	þ	1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	1	1 🗆 Yes		Specify:	,		Specific	nite
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Hygid other	Be Co	17. Father's Name (First, Middle, Last)		LOIN				me (First, Middle			a company
uld be Menta irked	To B	Jess Willi	ams			I	Losha	Walker	Wi	lliams	
2 sho and f is me		19a. Informant's Name/Relationship (Ty						ural Route Numb	-		ip Code)
1 and 1ealth sm 27 ther tr	1	Debbie Kirkenda		809 lace of Dispo		bara	Ct C	len Bu		e , MD	21060
ages nt of h		1 K Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, cre	matory or	other place)	0 7 7	/25/06			
artme ortant injury		4 □Donation 5 □Other (Specify) 21. Signature of up ral Servi License		_			_				Home, PA
Depa impo any ii		It &					ra Dr			a, MD	21122
Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death the cause on each line. Due to (or as a consequence)	tic	Pre-	shafter or aying, s	e C	ANCE	irrest,		Approximate Interval Between Onset and Death
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w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	uence of):							
artifica ling pt e as ti	Med	IF FEMALE:									ZZZZZZ
The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 mowths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3[□Ectopic p □ Other (s					23d. Date of deli Month	very Day Year
s that pred b	by Pt	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	inderlying	cause given ir	n Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
equire en sig ould b								1 🗆	Yes 2	□ No 3 □ Pro	bably 4 Donknown
has has	Completed								psy ormed?	prior to death?	topsy findings available ompletion of cause of
	a	25. Was case referred to medical	44			26	S. Place of De	1 ☐ Yes	- 1	1 Yes	2 No
Physician: this certific	To B	examiner? 1 Tes 2 No	fospital: 1 🗌 Inpatient 2 🗌	ER/Outpatie	nt 3 D	OA Other:	4 Nursing I	Home 5□Res	dence	6 □Other (Spec	ufy)
ding After fune		27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of M	28c. Injury at Work? 1 □ Yes	2 □ No	28d. Describe	how injur	y occurred	
Attended dealer dealer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factor			28f. Location (City or To			ral Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	edical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred nvestigation	at the time, on, in my opinion	date and place on, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the within To the somple	Me	29b. Signature and title of certifier				c. License nu				e signed (Monti	
		1. V.	MD			DS	3463	2_		4/24/0	ND 21061
5		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)		. 0		0		0 0
		31. Date filed (Month, Day, Year)	780 Registrar's Signa	ture	SOL	10000c	4 Kovo	d Gle	الهج	ornie 1	ND 31061
St Regist	ate	MAY 0 2 200	6 Mayers	550	A STATE OF THE PARTY OF THE PAR						

06-02764 Jason Woycio

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of Death	U	eg. No. 200	06 13790
Physician Medical Examine	er	Jason David Woycio	2. Date of Dea Month April 23, 2	Day Year	3. Time of Death 1242 hrs
	ľ	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital-Shock Trauma 4b. City, Town, or Location of Death Baltimore		4c. County of D	eath
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 069-72-6474 1 Months Days Hours Min.	8. Date of Bir Aug 5,	Fo	Birthplace (State or preign Country) Texas
Maryland 28a-f show any datonce		Usual Residence of Decedent			10d Inside City Limits 1 Yes 2 X No
i with the Maryland ins 23a or 28a-f sho be notified at once.		10e. Street and Number 10f. Zip Code 21157		0g Citizen of What (Country?
after death ral", or iter		11. Marital Status 1 X Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify:	Rican, etc.)	White, et	nite
21215-0036 uld be filed within 72 hours Mental Hyggene marked other than "natuu c event, the Medical Exam	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Driver	ed)	Deliver	,
21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica		17. Father's Name (First, Middle, Last) Gregory Woycio 18.Mother's Name (Carla J.		Maiden Surname)	
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental III. If item 27 is marked other traumatic event,	L	19a. Informant's Name/Relationship (Type, Print) Gregory Woycio/Father 19b. Mailing Address (Street and Number or Ru 3542 Oxwed Ct. Westmin	ıral Route Nun Ister M	nber, City or Town, S D 21157	tate, Zip Code)
Baltimore, MD 21215 permit Pages I and 2 should be filt Department of Health and Nennal H Important: If item 27 is marked injury or other traumatic event. It	Ł	1 Burial 2 X Cremation 3 Removal from State crematory or other place) Nonation 5 Other Specify: West Arundel Crematory 4-2		l	MD
	1	21. Signature of Poperal Service Licensee 22. Name and Address of Facility Amb r 1328 Sulphur Sprin 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	g Rd.	Arbutus MI	21227
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
ii je		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (prisease or injury that initiated			
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	lysician,	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	су	Month	Day Year
5, P.O. Buires that the definite state the definition of the detached if the phy by the definition of the Physical for the ph	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate burst after death completely filled in by the funeral director. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a sectional Certification: To Be Compilered by Physician	ompieted		24a. Was a autop perfor	sy prior med? death	
Vital Recystician: The librate in director, page	2 2 2 E	25. Was case referred to medical examiner? Hospital: 1 V Inpatient 2 ER/Outpatient 3 DOA Other Warring			
n of Vit ling Physic After this funeral dire	113	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2	8d. Describe h	now injury occurred	ther:
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Divi		determined	or Town, S	Street and Number or tate) Arunah Avenue,	Rural Route Number, City Baltimore MD
Division To the Bospital or Attent within 24 hours after death within 24 hours after death. To the Funeral Director: completely filled in by the Medical Certification	7 [7	29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated	ue to the caus	e(s) and manner as s	started
		29b Signature and title of certifier O.C.M.E.		29d. Date signed (Month, Day, Year)
	1	Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
State Registra		Date filed (Month, Day, Year) MAY 0 2 2006 32 Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** April 28, 2006 3:45 MC Mary Wilk /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7943 Oakwood Rd. Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 5, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗶 F 119-05-2327 85 Yrs. Pa. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at 1 ☐ Yes 2 XNo Dundalk Md. Baltimore Director 10f. Zip Code 21222 10g. Citizen of What Country? 10e Street and Number 3136 Yorkway USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Baltimore, Maryland 21215-0036 þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Retail 10 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ADR. Stella Kolinchak Martin Kolinchak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7943 Oakwood Rd. Glen Burnie Md. 21061 Kenneth Wilk son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 1 2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Oak Lawn Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 Part 1. Enter the disease, 1 complications that caused the deam Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List lonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colan (me Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has blirector, page 2 s To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Sons Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 ☐ Yes 2X No ဥ this After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 X Naturai 5 Pending М 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C [Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and title of certifier 29d. Dale signed (Month, Day, Year) 124356 alla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9103 Franklin Sq. Dr. \$2200, Balto MO 21237 Waterfield, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 2 2006 Registrar

			1 - For State Registrar	State of Marylan	-	artment of Hertificate of L			giene Reg. No:	15	13792
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea		Year	3. Time of Death
	Physici /Medio			ATTS				April	29 20	06	9:03 A M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		•	4c. County		. 1 . 1
	Funeral		Baltimore Washing 5. Social Security Number 6. S	ex 7. Age (In yrs.		Glen Bu	Il Under 24 Hrs.	8. Date of Birt (Month, Day	Anne		Idel place (State or Foreign ntry)
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	Mary -f eho	tor	MD Anne A	runde1 G	len Bu	rnie					1 ☐ Yes 2 反 No
	or 28	Director	10e. Street and Number			10f, Zip Code			10g. Citizen of \	What Cou	ntry?
	sth wi	rai	202 Daffodil Roa			21060				S.A.	
_	iter de	Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 12€2¥es 2 ☐ No		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Ameno ck, White,	can Indian, etc.
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212-0036	n 72 hours after desth with the Marylan "natures", or iteme 23s or 28s-f ehow adical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of worki	ing	16b. Kind of B	usiness/In	dustry
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yland	Mental Mental Brked c	ToE	James Thomas Wat	ts, Jr.			Diane	D. Dami	ico		
Mar	s 1 end 2 should f Heelth and Mer ttem 27 le marke other traumatic		19a. Informant's Name/Relationship (Mrs. Diane Watts			g Address (Street a				. ,	•
	1 end Heelth tem 27		20a. Method of Disposition		Place of Dispo	Daffodil : sition (Name of natory or other place	Road; Gle	en Burni Date	Le, MD 2 20c. Location -		
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daitimore,	permit. Peges Depertment of I important: If it eny Injury or o		21. Signature of Funeral Service Licen	ISBB	22	. Name and Address	s ol Facility Sin	gleton	Funera1	Home	e, PA
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			23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	h. Do not ent						Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Arten oscle Due to (or as a conseq	notic	Cargio	vascul	an us	sease		5 years
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X O D	w requires that the death certif been signed by the atlending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 Live birth 2 Feta	ildeath 3□	Ectopic pregnancy Other (specify)				te ol delive inth	ery Day Year
j.	the che	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	iballi 5	Ollier (specify)					
ν, J	The law requires that ste has been signed b age 2 should be deta	by Pł	Part II. Other significant conditions c	ontributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use cont	ribute to t	he cause of death?
ora Ora	equire							1 🗆 Y	res 2□No	3 ☐ Prot	pably 4 Unknown
Kecord	elawi hasb	Completed						24a. Was autop	sy	prior to co	opsy findings available impletion of cause of
VItal		e Col	25. Was case referred to medical					1 ☐ Yes	2 No	death?	2 No
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	To the Hospital or Attendin within 24 hours effer death. To the Funerel Director: Af completely filled in by the fun	edicai C	(Check only 2 Medical Exan	ysician: To the best of my kno niner: On the basis of examina	owledge, death	occurred at the tim	e, date and place, a	and due to the o	cause(s) and ma	anner as s	itated.
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signe		
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	3		31 (completed cause of death (Item	n a) (Type,	Print) C	71.4	'۔' ا ہے ا) ' یہ	MA 2	100	2
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature Di		J. Luines	ואיוופן	٠٠٠، ح	,107	J
	Registi	ar	MAY 0 2 2	2006	H. A	action .					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 10:15 AM M 17, 2006 April Anna Marie Ziemski /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ocean City Worcester Unit 16-77th Street | Months | Days | Hours | Min. | Sept 15, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F 82 Yrs. 1923 Maryland Director 217-16-1180 Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b County r than "neturel", or items 23s or 28s-f show the Madical Examinat must be notified at 1 ☐ Yes 2 No Worcester Ocean City Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16-77th Street Unit 3 21842 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: white Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than 9 Bookkeeping none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 Is marked oth any jury or other treumatic event 9008. Be 2 Joseph Lewis Schech Marie Anna Bond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Muller/daughter 16-77th Street Ocean City, MD 21842 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Wade/ Ronald S. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pant. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATTEROSCIEROPIC CARDINASCULAR DISERSE Physician /Medical Due to (or as a consequence of): Examiner Misery Disery DROM AM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760. physicien Physician/Medical SS IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Unknown as been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed2 Yes 2 No page 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: 26. Place of Death | Check only one Be 25. Was case referred to medical examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No after death.

Director: Aff investigation 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21 06 D46257 ecci 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SORUN, WIDZIEII 10324 OLD OCEMINIETY BLVD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 per fib 8855 5-12-06 (Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day April 30,2006 Zouck 7:27 p W. Jane 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 30,1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 21051144111797 Months Days Hours 1 ☐ M 2 🛛 F MD 213-07-1794 89 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Cockeysville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 USA 13801 York Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medica1 Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Stump Lewis J. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3721 Butler Road, Glyndon, MD 21071 John H. Zouck, II Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 5/1/06 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final noracic disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 NO 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit jo P.O. 1 Records, Division of Vital death. within 24 hours efter death To the Funeral Director: completely filled in by the

Examiner Physician/Medical page 2 should be Certification: To Medical

Physician

/Medical

Examiner

Director

Completed by Funeral

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10a. State

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other traumatic event, the Medical Examiner must be notified at

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ö Department of Important: If eny injury or once.

Baltimore,

IF FEMALE: à Be Completed

25. Was case referred to medical examiner? 1 🗌 Yes Manner of Death

1. Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) No charles St. Balto Rd 21204 BEDON 6701 MA

2006

31. Date filed (Month, Day, Year) State 0 Registrar

29a. Certifier

(Check only one)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 14, 2006 Day Year Physician 2040 P. M BETT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** 1 ☐ M 2 🐼 F Yrs 216-14-3253 83 Nov. 19,1922 Wash. Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show the Medical Exercitar must be notified at 1⊠Yes 2 No Director Lanham MD. Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 20706 9444 Washington Blvd. USA or items 23a Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 ☐ Divorced 'natursi', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WSSC Credit manager 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I James B. Ricks Cora Mae Gamble P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a John A. Betz - Son P.O. Box 248, North Beach, Maryland 20714 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: If it sany injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery | 04-18-06 Brentwood, Maryland 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Sexice/Lig 6512 N.W. Crain Hwy., Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mela **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a cur secuence off Examiner attending physician and for use as the burial-fransit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical After this certific funeral director, 26. Place of Death | Check only one Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 _npatient 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Mann Peath 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after death uneral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier R les Mel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tari 31. Date filed (Month, Day, Year) State APR 1 8 2006 Registrar

			For State Registrar		State of N	Marylan		artmen rtificat			and M	-	giene Reg. No	IIII	\$444 conjuint	379	6
8	Physicia /Medic		Decedent's Name (First, a JACQUES	Middle, Last)		BELV	'AL					2. Date of De Month APRIL	Da	y Yea	ar	3. Time of De 7 . 40a	
	Examin	e	4a. Facility Name (If not inst	itution, give s	treet and numbe	ər)		4b. City,	Town, or	Location o	of Death		40	. County of D	eath		
	Mary St.	Art C	Frederick	Memo 6. Sex			al last birthday)		Fred	eric		P Date of Pie	+h	Frede			ien
	Funeral Director		5. Social Security Number 433-63-511		M 2□F	86	Yrs.	Months		Hours	Min.	B. Date of Bir (Month, Da Dec.	19,	1919	Country F1	ce (State or F y) Cance	-oreign
	pug A	-	Usual Residence of Deceder 10a. State 10b. C			10c. Cit	y, Town or Lo	ocation							100	t. Inside City	Limits
	Maryli -f eho	tor		Frede	rick		M	idd1	etow	n						1 X Yes 2	□No
	72 hours after death with the Maryland "neturet", or tteme 23a or 28a-f ehow idjoal Examinar must be notified at	i Director	10e. Street and Number 102 Ivy	Hill	Dr.			10f. Zip	Code	1769)		10g. Ci	tizen of What		y?	
	death	Funerai	11. Marital Status	1	12. Was Decede Armed Force		S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race - A Black, W			
920	ours after	þ	1 Never Married 2 X 3 Widowed 4 Div		1 ☐ Yes 2[If Yes, Give Year or Date	₹ No		1 ☐ Yes				rican, etc.)		Specify: V			
5-0	be filed within 72 ho ital Hygiene. id other then "natur event, the Madical	Completed	15. Dec (Specify only	edent's Educ highest grade			16a. Dece (Give	dent's Usu kind of wo DO NOT u	rk done a	<i>lurina</i> mos	t of workir	ng	16b. K	(ind of Busine	ess/Indu	stry	
121	within 72 iene.	dwo	Elementary/Secondary (0	-12)	College (1-4d 5 +	or 5+)		irge		,			me	dicir	ıe		
pd 2	be filed with tal Hygiene. d other ther event, the M	Be C	17. Father's Name (First, M.							18. Mothe	er's Name	(First, Middle					_
ylar	should be nd Mental marked o	ToE	Edmond									Boso	-				
Maryland 21215-0036	d 2 T ts		Agnes Rag			er)						Middle					
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Dogration 5 ☐ Ott		emoval from Sta	C	lace of Dispo emetery, cre niths	matory or c	other place	mato		ate 4/19/(ocation - City			 D
Baltir	permit. Pages: Department of H Important: If ite ony injury or ot		21. Singulare of Fineral Se	and the same of the same of	PARA	K	4	ona"	ld dddreg	s of Faculit	omps	son Fu	ıner	al Ho	me		
			23a/Part1. Enter the disea	se, or compli	cations that caus	sed the death						Middl r respiratory a		wn, M	A	Approximate	
Separation of the Contract of	Physician		shock, or heart failure Immediate Cause (Final disease or condition	. List only on		5 P S1	S									nterval Betwe Onset and Dea	
	/Medical Examiner		resulting in death)		Due to (or	as a consequ	uence of):										
*	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ "		as a consequ	uence of):										
,09/	te be executed ysician and ie burial-transit	cal Examiner	that initiated events resulting in death) Last	°	Due to (or	as a consequ	uence of):										
687	2 2 9																
Box	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	111	3c. If yes, outcor 1□Live birth 4□Pregnant 9□Unknowr	2 ☐ Feta tat time of d	death 3	∃Ectopicp ∃Other(sp			-			23d. Date of Month		/ ∂ay Yea	ar
s, P.O	es that th igned by be detacl	by Phy	Part II. Other significent co			h but not res	ulting in the u	nderlying o	cause give	en in Part I	•	23e. Did	tobacco	use contribut	e to the	cause of dea	ith?
ord	w require been sig should b		MANCY	170P	ENIA							1 🗆	Yes 2	□No 3□	Probab	oly 4 0 0nk	known
Records,	e la has	completed										24a. Was auto perfo 1 Yes		24b. Were prior death	to comp n?	sy findings ava pletion of caus	allable se of
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to m examiner?	-							of Death	(Check only					
of \	Phys this al dii	J.	1 Yes 2 No	Н	28a. Date of I		ER/Outpatie			4 🗆 140		ne 5 Resi			Specify)		
on	ling After une	tion	1 Natural 5 F	ending vestigation	(Month,	Day Year)	Injury	M	28c. Injury Work 1 [] `	rai ?? Yes 2.∐		od. Describe	now inju	ily occurred			
Division	f or Attending after death. Director: After I in by the fune	Certification:	3 ☐ Suicide 6 ☐ C	could not be letermined	28e. Place of building,	Injury - At ho etc. (Specify	ome, farm, st	reet, factor	y, office		2	28f. Location (City or To			r Rural F	Route Numbe	or,
	Hospita 4 hours Funeral	edical C	29a. Certifier Concept one)	rtifying Phys dical Examir	sician: To the be ner: On the basis and manner	s of examina	wledge, deat tion and/or in	h occurred evestigation	at the tim	ie, date an pinion, dea	nd place, a th occurre	and due to the ad at the time,	cause(s	and manne d place, and	r as stat due to ti	ted. he cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of c	ertifier / /				29	c. License	number				ate signed (M		-	
	- 3 - 0		> Male	+Ver	ng				D-	-577	96		A	PRIL	17	7, 200	6
	5		3b Name and ddress of p	erson who co	empleted cause of	of death (Item	23a) (Type	Print) F	IFRE	Mall	M	1 2	170	/			
	Sta	ite ar	31. Date filed (Month, Day,	Year)	32. Re	strar's Signa	ture	Sand	Y ,	0	, (1			

			For State Registrar	State of Maryland /		rtment tificate			nd Me		giene Reg. No	006	13797
	G		1. Decedent's Name (First, Middle, Last)					2.	Date of Dea			3. Time of Death
	Physici		Leonard L	ither Burke						Month April	Da 15.	y Year 2006	7:11 P M
	/Medic		4a. Facility Name (If not institution, give			4b. City, To	own, or L	Location of		TOLIT		County of Deat	
	Examin	er										Mantaam	
			9518 Main Street 5. Social Security Number 6. Se		hirthday)	Dama If Under 1	1SCU Year	S If Under 2	4 Hrs. 8	Date of Birth		Montgom	ery hplace (State or Foreign
	Funeral		1)	5M 20 E	Yrs.		Days	Hours	Min.	(Month, Day	r, Year,	Co	untry)
	Director		213-18-9374 Usual Residence of Decedent	85					Iv	íay 28,	15	920 Mar	yland
	and		10a. State 10b. County	10c. City, To	wn or Loc	cation							10d. Inside City Limits
	she	ō	Marriand Mantage	Dom		_							1 ☐ Yes 2 ☐ No
	88-1 1-88-1	ect	Maryland Montgome	ery Dam	ascu	1					10- 01	A'	Λ
	if i	Funeral Director	10e. Street and Number			10f. Zip C					iog. Ci	tizen of What Co	unity?
	238	<u>ra</u>	9518 Main Street				2087					U.S.A.	
	e in de	ine	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Deceder Yes, specify	nt of His y Cuban	panic Orig , Mexican,	in? (Specif Puerto Ric	y Yes or No- can, etc.)		 Race - Ame Black, White 	
9	afte or It	正	1 ☐ Never Married 2 ☐ Married	1 XYes 2 □ No If Yes, Give		☐Yes 2		Specify:				Specify:	
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jieal Examirat must be notified at	l by	3 Widowed 4 Divorced	Year or Dates: WWII								Wh	ite
2	72 h natu	Completed	15. Decedent's Edi (Specify only highest grad		a. Deced	ent's Usual (kind of work OO NOT use	Occupat	tion urina most	of working		16b. K	(ind of Business/	Industry
2	within ene. then "	du	Elementary/Secondary (0-12)	College (1-4or 5+)			retired)				U.S	. Govern	ment
2	gien gien grth	Ö	8		Carp	enter							
	e filed at Hygid other vent,	Be (17. Father's Name (First, Middle, Last)					18. Mother	's Name (F	First, Middle,	Maider	n Sumame)	
<u>a</u>	ic e	To E	Leonard Frankli	n Burke				Anı	nie :	Laurie	S	ier	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of health and Mental Hygiene. Item 27 Is marked other then "netural", or Items 23a or 28a-f show other treumetic event. It e M-social Examiner must be notified at		19a. Informant's Name/Relationship (T	ype, Print) 15	9b. Mailin	g Address (S	Street ar	nd Number	r or Rural F	Route Numbe	r, City	or Town, State, Z	Tip Code)
Z	od 2 Ith a 27 Is		Brenda Phifer - D	aughter 1	11649	Leeh	i ch	Drive	- F	airfax	. v	irginia	22030
ø,	T ar		20a. Method of Disposition	20b. Place	of Dispos	sition (Name	of	- 1	Date	-		ocation - City or	
ō	in it of or o		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	-	atory or oth				2006			
Ė	nit. Pa artmer ortant: injury		' 4 ☐ Donation 5 ☐ Other (Specify,	the state of the s		Metho			4/19/			ascus, M	
Baltimore,	E 0 0 >		21. Signature of F) neral Service Licens	2(11)	22. Mc	Name and	Address orth-	of Facility -Will	iams	P.A.	Fur	neral Ho	me
ш	20 2 8 Q		23a. Part1. Enter the disease, or comp	Muum	26	6401 R	ide	e Roa	d. D	amascu	ıs.	Marylan	d 20872
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. D	o not ente	or the mode	of dying,	, such as c	ardiac or r	espiratory arr	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final		act	@ A V V	1.0						Onset and Death
4	/Medical		disease or condition resulting in death)	a. Due to (or as a con a ueno	9r+	c/y c	13	ras	6				7 7 7 3
	Examiner					scul	~~	1 -	cide	+			191
		Į.	Sequentially list conditions, if any, leading to immediate	b. CECE DCQ		5041	41	77 0	LILLE	. / \ /			7 12 1
	ed	Examiner	cause. Enter Underlying Cause (Disease or injury		1	-6	7	-+-					1/90
	and I-trar	xan	that initiated events resulting in death) Last	c. Myocard Due to (or as a consequence	101	LOT	21	ctroi	<u> </u>				7 / 9
Ő,	certificate be executed iding physician and ise as the burial-transit	Ω .		.1	' 1	1							1988
8760,	ate b hysic the b	dlcal		· hyperly	3-E CX	em	LA						
9	ng p	0	1F FEMALE:										
Вох	eath certific attending p	Z.	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ıth 3□	Ectopic pred	nancy					23d. Date of deli	
Ω.	death e atter ad for u	ici	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death		Other (spec						Month	Day Year
0	that the de ed by the detached	Physician/M	9 🗆 Unknown	9□ Unknown									
σ.	requires that the een signed by th rould be detache		Part II. Other significant conditions co	ontributing to death but not resulting	g in the un	derlying cau	se giver	n in Part I.	100	23e. Did to	bacco	use contribute to	the cause of death?
Vital Records,	sign sign d be	Completed by	atrial Fibrill	etron, Hyper	ten	SION	. de	epre.	55/60	1 □ Y	es 2	□No 3 Pr	obably 4 Unknown
Ö		ete		1 6)	1		040 1460		1	7417 1930
e	2 8 8	du	anemia, rer	19/ tailure						24a. Was a autop perfor	SV	prior to death?	topsy findings available completion of cause of
=	pa age	CO									2 N		2 🗆 No
ï	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death (0	Check only or	ne)		
+	Physicien: this certific ral director,	2	1 □ Yes 2 🕶	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	1 3□ DOA	Other	r: 4□Nur	sing Home	5 Resid	lence	6 □Other (Spec	cify)
J of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	. Time of Injury	280	c. Injury	at	280	d. Describe h	iow inju	iry occurred	
Division	Attending r death. sctor: Afte by the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	М		es 2□N	10				
·S	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	200. Place of injury - At norme,	farm, stre	et, factory,	office		281				ıral Route Number,
á	afte Dir	ert	4 Homicide	building, etc. (Specify)						City or Tow	m, stat	θ)	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 ★ Certifying Phy	/sician: To the best of my knowled	ige, death	occurred at	the time	e. date and	place, and	d due to the o	ause(s	and manner as	stated.
	Hos 24 h Fur stely	edical		iner: On the basis of examination and manner stated.									
	the the mple	Me	29b. Signature and title of certifier	. /		29c.	License	number			29d. Da	ate signed (Montl	h. Dav. Year)
	Z × Z		A ()	Kinney &	40				68				
			yourse of	11000				· · · · ·	60	~	Ap	oril 17,	2006
1	7+1		30. Name and address of person who o										0070
-1	L''		Joanne L. Kinney			urch S	Stre	et,	Damas	scus, 1	Mary	/Land 2	0872
	Sta	ate	31. Date filed (Month, Day, Year)	9 2006 Signature	K	has	11)						

		1 - For State Registrar	State of Maryland	d / Dep		nt of H	ealth ar		ntal Hyg		06	137	98
D1		1. Decedent's Name (First, Middle, Last,							Date of Deat Month	th Day	Year	3. Time o	f Death
Physicia /Medic		Ros	se M. W. Buck-	Lew					PRIL	14	2006	4:04	PM
Examin		4a. Facility Name (If not institution, give			1		Location of	Death		4c. Co	ounty of Death	1	
		SHINT AGNES HE				L7// er 1 Year	10RE	4 Hrs. D	Data at Dist		None	(2)	
Funeral Director		5. Social Security Number 6. Security Number 10 10 10 10 10 10 10 10 10 10 10 10 10	7. Age (In yrs. I	Yrs.	Months		Hours	Min.	Date of Birth (Month, Day, ept 28	, Yθar) , 191	.6 Chi	nplace (State untry) na	or Foreign
be been with rich nous are death with the maryand tall hygiene then "naturel", or items 23s or 28s-1 show of other then "naturel", or items 23s or 28s-1 show event, the Medical Examiner must be notified at		10a. State 10b. County	10c. City	r, Town or L	ocation.							10d. Inside C	ity Limits
Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.	ţō	MD Howard	Elk	ridge	2							1 🗌 Yes	2 € No
or 284	Funeral Director	10e. Street and Number				p Code			1	0g. Citizer	n of What Co	intry?	
23a	al	5877 Wood Valley 1	Road		2	21075				Unit	ed Sta	tes	
SE SE	nei		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dece If Yes, sp	edent of Hi	ispanic Origii n, Mexican, I	in? (Specify Puerto Rica	Yes or No- an, etc.)	14.	Race - Amer Black, White		
o E	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give		1 🗆 Yes	2 No	Specify:			Sp	pecity:		
al Ex	pa pa	15. Decedent's Edu	Year or Dates:	16a Dece	edent's Usi	ial Occupa	ation			16h Kind	of Business/I	sian	
fedic	olet	(Specify only highest grad	e completed)	(Giv	e kind of w	ork done a	furing most o	of working		TOD. Raild	01 00311163381	ildustry	
De.N	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Home	make:	r			Ow	n Home	:	
ent,	40	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (Fi	rst, Middle, I	Maiden Su	тате)		
tic e	To B	Wong Lum Sung					Yue S	Shau S	han				
r treuma		19a. Informant's Name/Relationship (T) Marian Buck-Lew/Da									own, State, Z 21075		
e to		20a. Method of Disposition	20b. P	lace of Disp emetery, cre	osition (Na	ame of other place	e)	Date		20c. Loca	tion - City or 1	Town, State	
5		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	BILIOVALI ITOIN STATE	ro Cr				1-17-2	2006	Caton	sville	, MD	
흔		21. Signature of Funeral Service Licens									's Fam		Tnc
E B		Mene Collina	- Vigle	4	112	old Co	olumbi	la Pik	e Ell:	icott	City,	MD 21	043
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death									Approxima Interval Be	te
an i		Immediate Cause (Final disease or condition	STROK	E								Onset and	
cal		resulting in death)	Due to (or as a consequ								-	2 0/10	٥
er		Sequentially list conditions	ATRIAL	FIB	RIL	LAT	70N					5 YET	HRS
-	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ience of).									
	Examiner	that initiated events resulting in death) Last	Due to for an a concess	ionno of):									
			Due to (or as a consequ	rence or).									
	edicai		d										
	/Me	IF FEMALE:	3c. If yes, outcome of pregna	ncv						226	d. Date of deli	1971	
	Physiclan/M	in the past 12 months?	1 Live birth 2 Fetal	death 3	□Ectopic p □ Other (s					230	Month		Year
	ysi	1 ☐ Yes 2 █No 9 ☐ Unknown	9□ Unknown			,,,			VA TABLES				
	by Pi	Part II. Other significant conditions co	ntributing to death but not resu	ılting in the	underlying	cause give	en in Part I.		23e. Did tol	bacco use	contribute to	the cause of	death?
									1 □ Y	es 2 📉	No 3□Pro	bably 4 🗆	Unknown
	Completed							-	24a. Wasa	n 2	4b. Were au	opsy findings	available
	E C								autops	ned?	prior to c death?	ompletion of	cause of
20.	Ü	25. Was case referred to medical					26 Place of	of Death (C	1 ☐ Yes :	1	1 🗆 Yes	2X No	
	0 0		lospital: 1 Depatient 2 🔲	ER/Outpatie	ent 3□ D	OA Othe					Other (Spec	rfv)	
		27. Manner of Death	28a. Date of Injury	28b. Time		28c. Injury	/ at		Describe ho			-11	
	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Work	c? Yes 2 □No	0					
6	Ę	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho	me, farm, s	treet, facto	ry, office		28f.	Location (St City or Town	reet and N	lumber or Ru	ral Route Nur	nber,
	Certification:	- Chimena	building, etc. (Specify	, 					Chy of Yow	i, Jiaie)			
	edlcal (29a. Certifying Phy (Check only one) 2 Medical Exami	ner: On the best of my knowner: On the basis of examination and manner stated.	wledge dea ion and/or i	nvestigatio	d at the tim n, in my or	na date and pinion, death	ulace, and occurred a	dua to the coat the time, d	ate and pl	d mannur as ace, and due	stated to the cause(s)
	¥e	29b. Signature and title of certifier			29	c. License			1	9d. Date s	igned (Month	Day, Year)	
		> Teodora M	veulen Ms	٥		PI	760	5		04.	14. 2	006	
		30. Name and address of person who con TEODORA M NICUESCO	empleted cause of death (Item	23a) (Type	Print)	JUE	BALTIN	MORE.	MAR	yiAN.	4. 212	29	
CA		31. Date filed (Month, Day, Year)	32. Registrar's Signa		- LIA Prof.	1					7		
Sta Registra		ST. Date filed (Month, Day, real)		24	-	a .							

			For 1 State	State of Maryla		artment of H			000		10700
		-	Registrar 1. Decedent's Name (First, Middle, Las	st)	061	Tillcale UI L	Jean	2. Date of Dea	th	11)	3. Time of Death
	Physici			_				Month	Day	Year	
	/Medio Examir		LaVerne 4a. Facility Name (If not institution, give	Brown street and number)		4b. City, Town, or	Location of Dea	_ April		2006 by of Death	10:49A ^M
	LXdiiii	ÇI	Shady Grove Ac		anital		ville		3.0	•	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yr	s. last birthday)	If Under 1 Year	II Under 24 Hr) (Voas)	9. Birth	place (State or Foreign
L	Director		233-66-7034	[™] 2□F 63	Yrs.	Months Days	Hours Mir	June 2	2,1942	Wes	st Virgini
	D .		Usual Residence of Decedent 10a, State 10b, County	100 (City, Town or Lo						104 1-14-05-11-1
	aryle hov	2									10d. Inside City Limits 1 Yes 2 No
	Ne M	Director	MD Montgo	omery	Gait	hersbur	<u>g</u>		0		
	hours after death with the Marylend turel', or Iteme 23a or 28a-f ehow at Examinat must be notified at	급	9 Chestnut St	- An+#211		10f. Zip Code 208	77		l 0g. Citizen of		ntry?
	eath	Funeral	11. Marital Status	12. Was Decedent Ever in	11.5 13.1			Specify Ves or No-		A.	can Indian,
	ter d	Ë	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No	10.0	f Yes, specify Cuba	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ack, White,	
9	urs a	ρ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ X 9o	Specify:		Speci	ity: Bl	.ack
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Maryland 21215-0036	12 sh h and h and T te m	1	19a. Informant's Name/Relationship (7 Lynnette Brown					Germant			
e)	1 and Healt em 2 ther	- 1	20a. Method of Disposition		. Place of Dispo		Ly way		20c. Location		
ဝွ	ages nt of nt of nt of nt of		1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren	natory or other place hurch Ce	· 1		Wheel		
Baltimore,	Tan Tan	1	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen				1	nowden E			
Ba	permit. Peges 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic engage.		on and	Xours (/			ton St F			
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the de							Approximate
В			Immediate Cause (Final	one cause on each line.		brillation		. ,			Interval Between Onset and Death
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Ö.	e exe ien a urial-i	Ĕ	resulting in death) Last	Due to (or as a conse	equence of):						
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×	eath certific attending p	Mec.	IF FEMALE:	02- 16							
Box	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	tal death 3	Ectopic pregnancy				ate of deliver	ery Day Year
о. О	at the de by the a tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant al time of 9□ Unknown	ueath 5	Other (specify)					
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ds.	uires that signed b	d by	hypertensum					1 🗆 Ye	es 2 No	3 🗌 Prot	pably 4/ Unknown
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≥	Physici this cer al direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe		Home 5 ☐ Reside		her (Speci	(v)
0	er t		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho			
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	Hos 24 hc Fun etely i	Medical		ysician: To the best of my ki liner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	estigation, in my op	e, date and place pinion, death occ	e, and due to the caured at the time, d	ause(s) and m ate and place,	anner as s and due t	o the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signe	ad (Month,	Day, Year)
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	V		30. Name and address of person who						1		
			Aaron Marc Sr	yder, MD 9	901 Me	dical Ce	enter I	or Rockv	ille,	MD	20850
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yea **Physician** APRIL 2006 1:24 PM Patrick Henry Bowen 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1**⊋**M 2□ F 47 Director 217-76-7090 March 17 1959 Chio Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
snt: if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Extended outs be notified at 1 ☐ Yes 2 ☐ No Maryland Calvert St. Leonard Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5007 Garrison Street 20685 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) dredoe operator Marcine Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred W. Bowen Ruth Fertig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta L. Bowen— wife 5007 Garrison Street St. Leonard MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Chesapeake Highlands Menbrial Cardens 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Port Republic Maryland permit. Pege Depertment of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic Md 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** INFARCTION 1 HOUR /Medical Due to (or as a consequence of) Examiner 1 HOUR PULMONARY EMBOLUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner 2 YEARS ettending physicien and for use as the burial-transit RENAL DISEASE The law requires that the death certificate be executed END STAGE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the el 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed' 2 PNo 1 Yes 2 No 1 Yes tor: After this certific the funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Fo the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 Abril 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 M.D. UNION MEMORIAL HOSPITAL, 9HAFOOR 31. Date filed (Month, Day, Year) 32. Registres Signature State

DHMH 17 Rev 1/2001

Registrar

2005 ▶

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			For State Registrer	State of Ma	aryland / Dep <i>Ce</i>	oartment e <i>rtificate</i>			ind Mer		iene eg. No.	16	13801
1. 1	Physicia /Medic		Decedent's Name (First, Middle, Last) William Wesle	y Brady						Date of Dear	3 200 6	5 Year	3. Time of Death 12:05 P
	Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or	Location o	f Death			ty of Death	
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W.	Funeral Director		4	M 2□F 82	(In yrs. last birthda Yrs.	y) If Under Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day rch 14	, Year)	Mary	place (State or Foreign ntry) yland
	show	5.0	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert		10c. City, Town or Huntingt								10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	the M	Funeral Director	10e, Street and Number			10f. Zip	Code			1	0g. Citizen o	f What Cou	ntry?
	with 38 or		3601 Coc Court				639				Inited		
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Mary	od 2 shallth and 27 Is n r traun		19a. Informant's Name/Relationship (Type Mary R. Brady – wi:			COX C						m, State, Zij	p Code)
Baltimore,	Pages 1 an nent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	moval from State	20b. Place of Dis cemetery, co Trinity	position (Namerematory or or or or or or or or or or or or or	ne of ther place	⁹⁾ Apri	Date	2006	20c. Location		
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4	8+1	1	30. Name and address of person who co Gerald Sterner M			e, Print)							
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			For State Registrar		State of Ma	arylan	-		nt of H te of L		d Ment		iene g. No.	006	3	802
	Obvojaj	~~	1. Decedent's Name (Fire	st, Middle, Last)			_					ate of Deat	h Day	Year		e of Death
	Physici /Medio		Frances	3	Ir	ene		В	rinkm	an	Č	XV_	15	06	12:	30PM.
j	Examin		4a. Facility Name (If not i	nstitution, give s	treet and number)	1 1		4b. Cit	, Town, or	Location of De	eath /		4c. (County of Dea	ith .	
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	alth alth 27 i		Howard H.	Brinkman	n / husba	and	1514	01d	towne	Manor	, Apt	1A,	Cum	berland	d, MD 2	1502
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Ë	Page nt: #		1 X Burial 2 Cre 4 Donation		emoval from State	1				Park (04/18	12006	Cı	umberla	and, M	D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinat must be notified at ODGe.		21. Signature of Fugeral	Service License	0					s of Facility				uneral	L Home	, P.A.
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	Physician: The law requires thet the death certif r this certificate has been signed by the attending rai director, page 2 should be delached for use a	by P	Part II. Other significant	conditions con	tributing to death b	ut not resu	ulting in the u	nderlying	cause give	n in Part I.	2	23e. Did tob	acco us	se contribute t	o the cause	of death?
rds	quire n sig uld b	De L									_	1 □ Ye	s 2 🗆]No 3 □ P	robably 4	Unknown
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Ö	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral birector: After this certificete ha completely filled in by the funeral director, page	Certification:	4 🗌 Homicide		building, et	.c. (Specify	"					ity or Town	, State)			
	spita hours nera / filler		29a. Certifier	Cartifying Phys	ician: To the best	of my know	wledge, deat	n occurre	d at the tim	e, date and pla	ace, and d	ue to the ca	ause(s)	and manner a	s stated.	
	Me Ho	Medical	(Check only 2 one)	Madical Examin	ar: On the basis o and manner st	f examinat	tion and/or in	vestigation	n, in my op	inion, death of	ccurred at	the time, da	ate and	place, and du	e to the caus	se(s)
	To the within To the comp	×	29b. Signature and title of	of certifier		_/	1	2	9c. License	number		25	9d. Date	signed (Mon	th, Day, Yea	r)
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	\propto		30. Name and address o	f person who con	mpleted cause of c	death (Item	23a) (Type.	Print) /		0) / ~	1 /) ^			2150
	TORD		Georgio-HA	man	CMI	10	25/	Sist	OP	Wals	LR	oad	C	6/20 umbe	Mana	dun
	Sta		31. Date filed Month, Da	1 7 200E	32 Aegistr	ar's Signa	ture	and the	,							
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Natalina Bofrone April 12, 6:25 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F Months 578-10-3895 93 Director 1912 Italy Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits worde rthen "naturel", or iteme 23a or 28a-f eho the Medical Exposition is ust be notified at 1 ☐ Yes 2 🔀 No Funeral Director Prince George's Maryland Hyattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 808 Sheridan Street 20783 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 Specify:White 1 ☐ Yes 2 No Specify: Š 3X Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ŕ Seamstress Textiles Pages 1 and 2 should be filed viment of Heelth and Mental Hygie tant: If Item 27 is marked other toury or other treumatic event, the Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Antonio Saraceni Maria Trentine 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Santa Scott/Friend 3042 Morris Court, Owings, Maryland 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 💆 Other (Specify) Entombment April 2006 18 permit. Page Department of Important: If eny injury or once. 9 Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Ligensee Francis Addess Collyins Funeral Home Inc. 500 University Blvd, W, Silver Spring, Md 20901 23a. Part? Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mayky Congestive Hear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires thet the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. To Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No be detached Records, P.O. the 9 Unknown 9 Unknown Š signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of daath? Posi 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has this certificete 2 DNo 1 ☐ Yes lovanic Obstructive of Vital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2/ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 100 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#10e, perFH, 4/17/06, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2866 Physician April 1 13^y. 5:05A M Betman Evelyn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | AUG. | 11, 1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** NewYork 1 □ M 2 🛱 F 87 Yrs. 577-22-8599 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a State 10b County r than "naturel", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 TYYes 2 No Montgomery Village Directo Maryland Montgomery 10e, Street and Number 19310 Club House Road 10f. Zip Code 10g. Citizen of What Country? United States of America 19310 Club House Road 20886 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 ģ 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Himportant: If Item 27 is marked oth any injury or other traumatic event ADR. Be Beatrice Rosenbloom David Harris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20804 Shakespeare Drive Germantown, MD 20876 19a. Informant's Name/Relationship (Type, Print) Jo Ann York - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 ☐ Cremation 3 N Removal from State King David Memorial 04/17/06 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc 21. Signature of Fundral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner oraso Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed the attending physiclen end that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown peed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending within 24 hours after deeth.

To the Funeral Director: Aft
completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 15225 SLCU Goldber 31. Date filed (Month APR 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🖯 13805 1 - For State Registra Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 0929 Barrera 2006 Vasque Z April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner of Maryland Medial Che Baltimore Baltimore City University If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 28 1 □ M 2 🔀 F 0 Yrs. Director Baltimore, MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan and of Health and Mental Hygiene.
ant; if item 27 is marked other than "natural; or iteme 23a or 28a-f show ury or other than "ury or other than ury or other than after or item and the notified as 1 ☐ Yes 2 ☑ No Maryland | <u> Montgomery</u> Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 20902 12233 Dalewood Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 x Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White <u>Guatemalan/Salvadoran</u> Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) N/AN/AN/A18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be <u>Blanca Yanira Barrera</u> Marco Antonio Vasquez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Silver Spring, Maryland 20902 12233 Dalewood Drive Marco Antonio Vasquez Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0= 0 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven permit. Page Department important: If 4 □ Donation 5 □ Other (Specify) PE O Apr. 18, 2006 Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Value Elon Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Extreme Prematurity Physician /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the attending physicien and debe detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 10 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? page 1 ☐ Yes certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funerel Director; 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 - Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and utile 29d. Date signed (Month, Day, Year) of certifier 188 3606 HILL H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marylandimedical Ctv 341+ University O. LAWRENCE ot

State Registrar 31. Date filed (MoAPRY.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per ME,G856,06/29/06dhb 1 - State RegistrerWCHD/SH 4/20/06 per FH Certificate of Death Reg. No. 2 Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Caroline Josephine Brown 2006 Dril /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington County Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, oct 11 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 ☐ M 2 💢 F Yrs. 1920 Director 85 212-14-7704 Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examinar must be notified at Y☐Yes 2☐No Director Maryland Washington Hagerstown Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Itema 23a or 8507 Mapleville Road 21713 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. illed within 72 hours after d Il Hygiene. other then "natural", or Item 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: ģ 3

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□ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witt Department of Health and Mental Hygiene Important: If Item 27 Is marked other the eny injury or other traumatic event, Insuppress Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ James William Murray Carrie Rinehart Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 19829 Bennie Drive Hagerstown Maryland 21742 Dixie I. McNaney (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 4-19-2006 Smithsburg Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee wy scurps 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Subdural the mounted **Physician** /Medical Due to (or as a consequence of): Examiner CERTIFY O DBY OF EXAMINATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physicien Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending atural subject fell 04/12/2006 Unknown 1 ☐ Yes 2 No death. investigation 2 XAccident To the Hospital or Attank within 24 hours after deal? To the Funerel Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
at home 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 T Homicide 8507 Mapleville Road 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 106 D060396 30. Name and address of person who, completed cause of death (Item 23a) (Type, Print) 1126 1126 Ogal 32. Registrar's Signature 44-3 nuist 31. Date filed (Month, Day, Year) State APR 20 2006 Registrar

06-02483 Jimya Gwendoly		1- For State	Pleas State of Mary			Health and		_	Pog No	2006	1900
Physicia Medical Examin	n/ i	Registrar 1. Decedent's Name (First, Mic Jimya Gwend	dolyn Clar	k				2. Date of De Month April 11,	2006	Year	3. Time of Death 1527 hrs
		4a. Facility Name (if not institu Malcolm Grow Hosp		number)	4	c. City, Town, or L Camp Spring				County of Death	e's
Funeral	_	5. Social Security Number	6. Sex	7. Age (in yrs. la	ast birthday)		+	8. Date of B	irth (MM/DI		hplace (State or Foreigi
Director		578-41-7296	1 M 2 X F		Yrs.	Months Days	Hours Min	Decem	ber 1		Wash. DC
0		Usual Residence of Decedent 10a. State 10b. Count		10c. City,	Town or Location	n					10d. Inside City Limits
and show	ŏ	DC		Was	hington						1X Yes 2 No
Maryl r 28a-1	Director	10e. Street and Number				10f. Zip Code				n of What Cour	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Examiner must be notified at once.	Funeral		Married 12. Was Do Armed 1 Yes Divorced If Yes, Give Y	ecedent Ever in U. Forces? 2 X No	If Ye	20032 Decedent of Hisps, specify Cuban,	Mexican, Puerto	ecify Yes or N	0- 14	d State Race - Americ White, etc.	can Indian, 8lack,
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221 hould b nd Mer is mar	2	19a. Informant's Name/Relation				Address (Street	and Number or R	Rural Route Nu			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		Jimmie Clark 20a. Method of Disposition	Jr. /Fathe			lantic S		05 Wash		on DC 20 cation - City or	
Ore ges 1 a t of He t frit		1 X 8urial 2 Cremati	tion 3 Removal	from State	crematory or other	er place)					
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Physician /Medical `xaminer	,	23a. Part I. Enter the disease, failure. List only one caus Immediate Cause (Final disea or condition resulting in death, Sequentially list conditions,	use on each line ase a. Sudden	unexplaine a consequence o	xd death i		uch as cardiac or	respiratory ar	rest, shock	s, or heart	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be deached for use as the burial	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 ✓ No 9 L	n the 1 Live	 outcome of preg birth gnant at time of de 	2 Fet	al death 3 er (Specify)	Ectopic pregna	ncy		Date of delivery lonth E	day Year
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ivisi or Att after de Direct	Certification:	X	ould not be	ace of Injury - At he		-	ilding, etc	28f. Location	(Street and	Number or Ru	ral Route Number, City 11 Drive Apt.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternopletely filled in by the funeral director, page 2 should be detached for a	ledical Cerl	29a Certifier (Check only 1 Certifying	Physician: To the bearing Physician: To the bearing Physician and the basic Physician and Physician and Physician and Physician and Physician and Physician and Physician and	est of my knowled		ed at the time, dat	e and place, and	due to the cau	estvill use(s) and	.e, MD manner as start	ed.
To t with To t	Med	29b. Signature and title of certi	and manner			29c. License				te signed (Mor	
		Patture Que 30. Name and address of pers	would -	- Pollo	230)	O.C.M				12, 2006	
R		Patricia Aronica-Pol		stant Medical I		111 Penn Str	eet, Baltimore	e, MD 2120	01		

Registrar

State 31. Date filed (Month, Day, Year) gistrar APR 2 6 2006

Registrar's Signature

ORIGINAL

			1 - For State Registrar	State of Maryla		artmen				R	eg. No.	906	Barry Legis	3808	
	Physici	an	Decedent's Name (First, Middle, Last	t)						Date of Dea Month	th Day	Yea	ır	3. Time of Death	
	/Medic		CHESTER	J.	CRESTV		SR.			APRIL	14	200		8:12 A M	
	Examir	er	4a. Facility Name (If not institution, give					Location of I	Death			County of D			
			6500 KNOLLBROOK I		rs. last birthday)	HY.		VILLE	LHrs o	Date of Birth		RINCE			
15	Funeral		5. Social Security Number 6. Social Security Number 1.	© M 2□ F 66	rs. iast birtnoay) Yrs.	Months	Days		Min.	(Month, Day	, Year)	0 5.7	Country	e (State or Foreign	7
	Director		Usual Residence of Decedent	00		11		l	HI	KIL 3	134	, M	АЗПІ	NGTON, DC	_
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation							10d.	. Inside City Limits	
	Mar.	ţo	MD PRINCE (GEORGE'S	HYATTS	VILLE								1X Yes 2 □ No)
	or 28	Funeral Director	10e. Street and Number			10f. Zip	Code			1	0g. Citi:	en of What	Country	?	
	23a	a	6500 KNOLLBROOK	DRIVE		2	20783	3			U.	S.A.			
	r dea	iner.	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Deced	dent of H	ispanic Origir In, Mexican, F	n? (Specif Puerto Ric	y Yes or No- an, etc.)		4. Race - A Black, W			
36	or it	Y.	1 Never Married 2 Married	1 GYes 2 □ No N If Yes, Give	AVY	1 🗆 Yes		Specify:				Specity:			
21215-0036	72 hours after death with the Maryland naturel', or items 23a or 28s-f ehow disal Exantier must be notified at	d by	3 Widowed 4 Divorced	Year or Dates: 19		de este 11-	-10	-11			105 16	nd of Busine	BLA(·	_
<u> </u>	n 72 nal	Completed	15. Decedent's Ed (Specify onfy highest gra	de completed)	(Give	dent's Usua kind of wo DO NOT us	rk done d	durina most o	of working		10D. KII	id of Busine	Sarmous	oury	
12	within ene. then "	m C	Elementary/Secondary (0-12)	College (1-4or 5+) 2 YRS		UMBER		•			CO	/ERNME	ידיאי		
q	be filed within 72 hours after death with the Marylan lat Hygiene. Id other then "naturel", or items 23s or 28s-1 show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)	2 110		OTIDET		18. Mother's	s Name (F	irst, Middle,			1111		_
Maryland		To Be	JOHN HOWARD CRES	TWELL				CLAR	A	THOMAS	S				
ary	s 1 and 2 should F Heelth and Mer Item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address	(Street	and Number	or Rural F	Route Number	r, City o	Town, State	e, Zip Co	ode)	_
	elth a		BARBARA CRESTWE	LL/WIFE	6500	KNOLI	LBRO	OK DRI	VE H	(ATTSV	ILLE	.MARYI	LAND	20783	
e,	es 1 a of Hee of Item r othe	3	20a. Method of Disposition	I	b. Place of Dispo	osition (Nar	me of		Dat			cation - City			
Ĕ	Pages nent of ant: If It ary or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ROCK CRE	EEK CH	EMETI	ERY 4	/21/2	2006	WAS	HINGTO	ON,D	С	
Baltimore,	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licen	see 10	2:	2. Name ar	nd Addres	ss of Facility	J.	B. JE	NKIN	IS FUN	ERAL	HOME	
<u> </u>	Dep Imp		LD.Y-	hall	7	7474]	LAND	OVER R	OAD I	LANDOVI	ER,M	ARYLAN	ND .	20785	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the done cause on each line.	eath. Do not en	ter the mod	de of dyin	g, such as ca	ardiac or r	espiratory arr	est,		A In	pproximate iterval Between	
	Pnysician		Immediate Cause (Final disease or condition	Heart	Failure									nset and Death nediate	
	/Medical Examiner		resulting in death)	Due to (or as a con											
	Examiner	L	Sequentially list conditions,	b	ic Aort	ic St	enos	is & C	AD				3	years	_
	pe is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	age Rena	al Di	6626	Δ					10	******	
_	be executed icien and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a con		- DI	ocub						10	years	
8760,	sicien and burial-transit	cal E			s Melli	tus							20	years	
687	~ ~			, d.										-	
×	leath certifical ettending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre							1	3d. Date of	delivery		
Вох	death etter	ciai	in the past 12 months?	1 Live birth 2 ☐ f		⊒Ectopic p ⊒ Other (sp		*				Month	Da	ay Year	
P.O.		hysi	9 ☐ Unknown	9□ Unknown							_1				_
	The law requires that the ste hes been signed by th bage 2 should be detache	by P	Part II. Other significant conditions of	ontnbuting to death but not	resulting in the u	ınderlying o	cause giv	en in Part I.		23e. Did to	bacco u	se contribut	e to the	cause of death?	
ğ	quire on sig	ed tr							_	1 🗆 Y	es 2[□No 3□	Probab	ly 4 ² ∏Unknowr	١
Records,	law request been 2 shoul	Completed								24a. Was a		24b. Were	autops	y findings available letion of cause of	8
	The I	E			-			•		perfor	med?	death	17	□ No	
ta	lan: rtifice ctor, p	Bec	25. Was case referred to medical examiner?					26. Place o	of Death (Check only or		<u> </u>			
<u></u>	Physiclan: this certific ral director,	2	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient		nt 3 DC	Oth Oth	er: 4 ☐ Nurs	ing Home	5 Aesid	ence (Other (S	Specity)		
0			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o		28c. Injur Wor			d. Describe h	ow injur	occurred			
Sio	eatl or:	cati	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2□No							
Division of Vital	7 2 2 2	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st ec <i>ify)</i>	reet, factor	y, office		28	f. Location (S City or Tow			r Rural F	Route Number,	
	urs a urs a erel C		One Continue 470 Continue m	To the best of	to a dedead of a				1					- 4	_
	To the Hospital of within 24 hours af To the Funerel D completely filled in	Medical	29a. Certifier 1 △ Certifying Ph (Check only 2 ☐ Medical Examone)	ysician: To the best of my niner: On the basis of exan and manner stated.	knowledge, deal nination and/or in	th occurred ivestigation	at the tin n, in my o	ne, date and pinion, death	place, and occurred	at the time, o	ause(s) late and	place, and	r as state due to th	ed. le cause(s)	
	ithin ithe	Med	29b. Signature and title of pertifier	and mariner stated.		29	c. Licens	e number		- 2	29d. Dat	a signed (M	onth, Da	y, Year)	_
	or tive		FERMIN !	4 100	MW	3/	30C	5020	OC			4/18/		•	
^	(2)111		30. Name and address of person who	completed cause of death	Item 23a) (Type							10-1	- 17.5 ==		
K	(4) IVa		Dr. Judith Veis,	•	ing st.		Wash	ington	. DC	20010)				
100	Sta	ate	31. Date filed (Month, Day, Year)	. Registrar's S			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	LIIE COII	<i>DU</i>	20010	<i></i>				
le "	Regist		APR 1 9 200	Registrar's S	& Ans										

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0 4 Physician JALANIA COLEMAN 10 2006 05:25AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Woodside Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/18/1973 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Washington, DC 577-88-9677 32 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Itiu Mudical Examinar must be notified at Washington \mathbb{C} n/a 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2341 Skyland Place SE 20020 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, I'llu Medical Exam har once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Specif**Black** þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Aid Counsler Private 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brenda Terry William A. Smallwood 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2341 Skyland Place SE Washington, DC 20020 Brench Terry Brown Mother 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD Riverdale Park Crematory 04/17/2006 22. Name and Address of Facility 21. Signature of Funeral S 814 Upshur Street NW Wash, DC 20011 Bianchi Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** AIDS

Due to (or as a consequence of) years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pissase or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Day Month Year jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown been signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 4x Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Encephalography 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Seizure Disorder has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 XNo 2 filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature an 04/14/2006 My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunesti K. Gupta, MD 9801 Georgia Ave Suite 220 Silver Spring, MD 20902 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2006 Registrar

			For State Registrar	State of I	Marylan		artment of H rtificate of L		Mental Hy	giene Reg. No.	006	13810
	Physici /Medic		Decedent's Name (First, Middle, La.	,	et Con	cetta	Conway		2. Date of De Month April 1	Day	Year	3. Time of Death 3:00 A. M
	Examin		4a. Facility Name (If not institution, give		er)		4b. City, Town, or	Location of Dea			ounty of Death	
			4115 Woodrow I		A (I		Bowie If Under 1 Year	If Under 24 Hr			nce Ge	
	Funeral Director		579-42-6059	ex □ M 25€ F	Age (In yrs. I	Yrs.	Months Days	Hours Mir	8. Date of Bir (Month, Da Aug. 7	y, Year)		place (State or Foreign intry) Sylvania
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary -1 eh	tor	MD. Prince (Georges		F	Bowie					1 Yes 2 □ No
	r the	Director	10e. Street and Number				10f. Zip Code			10g. Citize	on of What Cou	intry?
	deeth with the Maryland ms 23a or 28a-f ehow rroust be notified at	raiD	4115 Woodrow Lar	ne			20	0715		USA	4	
2-003p	urs after el', or ite	by Funeral	11. Marital Status 1 □ Never Married 2 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? [∑tNo		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2ऒ No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No orto Rican, etc.)	1	Race - Amen Black, White Specify: Whi	, etc.
ה	2 5 3	etec	15. Decedent's Ed (Specify only highest gra	ducation ide completed)		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of w	orking	16b. Kind	d of Business/Ir	ndustry
7	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		tice mana			Real	L Estate	e Appraisal
ם פ	filled Hygi Sther	Be Co	17. Father's Name (First, Middle, Last)	l					ame (First, Middle	, Maiden S	u <i>ma</i> me)	
<u>a</u>	Aental Aental rked c	To B		Joseph Do	minic	Ligne	lli	Elv	vira Sper	randec		
Mary	2 should and Men ie marke aumatic		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numb	er, City or	Town, State, Zi	p Code)
e, e	s 1 and 2 should I Heelth and Mer Item 27 ie marke other traumatic		Cynthia A. Pall:	ia – daug			Woodrow :			-		
altimore	permit. Peges 1 Depertment of H Importent: If Ite any Injury or ott		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications)	y)	Md.	Vete	sition (Name of natory or other place	tery ^{04–2}		Crown		own, State , Maryland
ŭ	perm Depe Impo any I		21. Signature of Fulleral Service Elegi	8 M	call		2. Name and Addres		Beall Fu			20715
į			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that cau	sed the death h line.			g, such as cardi			aryland	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a P	as a consequ	5.5	Cancer				1	2,5 year.
	Examiner			Due to (or	as a consequ	dence on):						
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	uence of):						
	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c								
Ď,	be exected a		resulting in death) Last	Due to (or	as a consequ	uence of):						
08/60	ficate be executed physicien and is the burial-transi	edical	•	d								
C. BOX C	death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown		n 2 ☐ Fetal tat time of de	death 3	Ectopic pregnancy Other (specify)			23	d. Date of deliv Month	rery Day Year
7.	requires that the neen signed by th hould be detache	by Pt	Part II. Other significant conditions of	ontributing to deat	h but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
	quire an sig tuld b								10	Yes 2□	No 3□Pro	bably 4 Dunknown
ı Kecoras,	The lay ate hes page 2	Completed							24a. Was auto perfe 1 \(\text{Yes}	ormed?	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
VII A	Physicien: r this certificatel director,	Be	25. Was case referred to medical examiner?						eath (Check only	one)		
	Phy this ald	10	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inp		ER/Outpatier		4 Nursing			Other (Speci	fy)
DIVISION OF	ding h. After fune	tlon	1 Matural 5 ☐ Pending	(Month,	Day Year)	28b. Time o Injury	Worl	yat k? Yes 2∐No	28d. Describe	now injury	occurred	
<u>s</u>	Attending in death. ector: After by the fune	ifica	3 Suicide 6 Could not b	e 28e. Place of	Injury - Al ho	me, farm, str	reet, factory, office		28f. Location	Street and	Number or Rui	ral Route Number,
5	s afte	Certification:	4 Homicide determined	building	, etc. (Specify	')			City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeret Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1	niner: On the basi	s of examinat	tion and/or in	h occurred at the tin vestigation, in my o	pinion, death occ	curred at the time,	date and p	lace, and due	to the cause(s)
	To t To t	Σ	29b. Signature and little of certifier	Mn			29c. License	e number		29d. Date	signed (Month	Day, Year)
)			My WL				000	5780	2	Apri	1 18,	2006
	(8)		30. Name and address of person who Wells Messers in a 1 Date filed (Month Day Year)	ith MD	of death (Item	23a) (Type,	the broom	duay.	Baltono	re, 1	Maryla	Day, Year) 2006 21231
Ž,	Sta Registr	- 4	31. Date filed (Month, Day, Year) APR 1 9 200	6 Ken	istrar's signa	Local	le	-				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 16, 2006 MAE ETHEL CRAMER 4:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing & Rehab. Ctr. Walkersville Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 6, 1916 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🛱 F 297-38-4256 89 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or Items 23s or 28s-f show treumstic event, the Medical Examinar mast be notified at 1√PYes 2 No Directo Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 West, Frederick Street 21793 U.S.A. Funeral r death 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lee Rawson Dessie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tret once. Gregory E. Cramer / Son 4303 Calvert Circle, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 4/17/06 `4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature of Funeral Service Lice 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that edused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician woul disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner zheine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 9 pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 Yes 2**X** No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death.

I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 04-17-2006

Registrar

State

who completed cause of death (Item 23a) (Type, Print)

MD

Lloyd E. Halvorson,

Y 1 8 2006

1475 Taney Avenue, Frederick, MD 21701

			1 10430 1	State of Mary				•	ene				
			1 - State Registrar			rtificate of i			g. No. 0 0 6	13812			
	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death			
	/Medic		Daniel		Chris	ty		April	11 2006	7:24 P M			
	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h			
			8804 Lew Wallace				bana	,	erick				
	Funeral		5. Social Security Number 6. Sec		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 20,	Year) 9. Birt	hplace (State or Foreign untry)			
	Director		Usual Residence of Decedent	5 S				Aug. 20,	1946 Nev	w Jersey			
	yland now		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits			
	Man	ģ	Maryland Frederic	ck	Urba	ana				1 ☐ Yes 2 ☑ No			
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?			
	23a c	a D	8804 Lew Wallac	e Road		2170)4		United :	States			
	dea	ner	11. Marital Slatus	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,			
98	or it	by Funeral	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2 ☒ No		rican, etc.)	Black, White Specify: W	hite			
21215-0036	10a. State 10b. County 10c. City, Town or Location Maryland Frederick Urbana								Specify: W				
15-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Civil Engineer							ing 1	6b. Kind of Business/	Industry			
12	College (1-4or 5+) Selementary/Secondary (0-12) Selementary (0-12) Selementary (0-12) Selementary (0-12) Selementary (0-12) Selementary (0-12) Selementary (0-12)								Water Sup	.1.,			
	College (1-4or 5+) 5+ Civil Engineer 17. Father's Name (First, Middle, Last)						18. Mother's Name	e (First, Middle, M		рту			
an	17. Father's Name (First, Middle, Last) Daniel S. Christy Alice							H-11	,				
Maryland	2 should and Men le marke sumatic	-	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street a			City or Town, State, Z	Tip Code)			
									Maryland	21704			
J.C	of Health of Health (Item 27 I		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of matory or other place	101		Oc. Location - City or	Town, State			
Ĕ	Pages nent of ant: If It ary or o		1 ☐ Burial 2 【☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			Cremator	April	1 17, 006 Ne	ewark, New	Jersev			
Baltimore,	permit. Pages of Pepertment of Himportant: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A.										
<u> </u>	89 5 9				16	21 Opossu				yland 21702			
			23a. Part1. Enter the disease or compli shock, or heart failure. List only or	cations that caused the ne cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between			
1	Physician		Immediate Cause (Final disease or condition	Atheros	cleroti	c Cardy	ovascula	i disc	054	Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):			- 00000		10003			
	Lxummer		Sequentially list conditions,)									
	ped list	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence or);								
	eath certificate be executed ettending physicien and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):								
760,	e be risicient	cail		1									
68	tificat ig phy as th												
Вох	endin endin	Ş	230. Was decedent pregnant	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	regnancy	Ectopic pregnancy			23d. Date of deli	very			
	The law requires thet the death certifica ste hes been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 Yes 2 No	4 Pregnant at time		Other (specify)			Month	Day Year			
P.0	et the	بالح	9 Unknown										
	signed k	۵	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.		acco use contribute to				
Records,	w requir been si should l	ted	- 144 perien	109		· · · · · · · · · · · · · · · · · · ·		1 L Yes	2 No 3 □ Pro	obably 4 Unknown			
lec	e law hes b	ag l	Diabetes	Melliy	US			24a. Was an autopsy	prior to d	topsy findings available completion of cause of			
H H		1 yes 2								2 □ No			
Vital	ysiclen: Th is certificate director, pag	25. Was case referred to medical examiner? 26. Place of Death (Check only one)											
ō	S S S S S S S S S S S S S S S S S S S									cify)			
5	ding Ph. h. After thi funeral	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	Worl	k? Yes 2 □No	200. Describe nov	injury occurred				
Division	Attendi death. octor: A by the fu	flca	3 Suicide 6 Could not be	28e. Place of Injury -	Al home, farm, str			28f. Location (Stre	eet and Number or Ru	ral Route Number.			
Ö	s effe	erti	4 Homicide	building, etc. (S	pecify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,					
	papits hours unera		29a. Certifier 1 Certifying Phys	sician: To the best of m	y knowledge, death	occurred at the time	ne, date and place,	and due to the cau	use(s) and manner as	stated.			
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examinations)	ner: On the basis of exa and manner stated.	imination and/or in	vestigation, in my of	pinion, death occurr	ed at the time, dat	te and place, and due	to the cause(s)			
	To t To t	Σ	29b. Signature and title of certifier	7.		29c. License			d. Date signed (Month				
			Clay X	oliver	MD	23	7197	1	pril 12	,2006			
	B		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	1	1	1 110	21701			
			31. Date filed (Month Dep Year)	M / Sigistrar's	West	1-Str	ect tro	ederici	K, MU.	21701			
	Sta		APR 1 8 20	006 32. gistrar's	Jigiralula	Carrie			*				

State of Maryland / Department of Health and Mental Hygiene | | | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 9:38A M DOUGLAS ELLIS CLARKE 13,2006 4c. County of Death /Medical APRIL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda

Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Onths | Days | Hours | Min. | Mar. 17,1936 Suburban Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 XM 2 ☐ F 70 Director 217-34-2150 Maryland Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f ahow 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 ahov any injury or other traumatic event, the Medical Examinar must be notified any once. Funeral Director MD Montgomery 1 De 2 □ No Poolesville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 19005 Jonesville Terr 20837 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 14. Race 1 No 1956-1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 1957 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) HVAC Heating & Elementary/Secondary (0-12) College (1-4or 5+) HVAC Supervisor lyr Air Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Millard E. Clarke Beulah Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19005 Jonesville Terr Poolesville, MD20837 June Clarke- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) <u>Jerusalem</u> Cem 4/18/06 Poolesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home, PA 20018 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the displaye, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stage Chronic Obstructive Pulmonary Disease /Medical resulting in death) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Congestive Heart Failure Due to (or as a consequence of): P.O. Box 68760 ettending physicien Physician/Medical Acute Renal Failure IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery cete hes been signed by the etter page 2 should be detached for i 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 100 Sivision of Vital 2 No 1 Yes Hospital or Attanding Physician: After this certification, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D062999 April 14, 2006 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Petek Donmez, 11613 Toulone Drive, Potomac, MD 20854 MD31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 18 2006

aRKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#8, perInf, 638,8726/6 II

State of Maryland / Department of Health and Mental Hygiene | | | | | |

State Registrer MEND#29dperMF4/18/06,BMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 13 2006 6:00 A M Wai Wah Chi April Fung /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Montgomery Montgomery Village Health Care | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 16, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 90 213-27-3376 Yrs Director China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28e-f ahow the Medical Examinar must be notified all 1 ☐ Yes 2X No Directo MD Montgomery Montgomery Village with the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9952 Lake Landing Road 20886 China filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>م</u> Asian 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nit. Pages 1 and 2 should be nartment of Heelth and Mental ortant: If item 27 is marked o Chi Fai Fung Ho Pang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) y injury or other ti Andrew Y. Fok / Son 9952 Lake Landing Road, Montgomery Village, MD 20b. Place of Disposition (Name of Date 20a, Method of Disposition 20c. Location - City or Town, State cemetery, crematery or other place). April 15 2006 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any in DeVol Funeral Home, 10 East entra Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Tumor /Medical Due to (or as a consequence of): Examiner Pancoast Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead of the cause of the cau Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arthritis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Osteoporosis 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After s after dec. 1 XNatural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medica completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1P2 Driller NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti , M.D., 19529 Doctor's Drive, Germantown, MD 20874 31. Date filed (Month, Day, Year) 32 negistrar's Signature APR 18 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		Reg. No.		10010
	61		1. December 1 tallie (1 hot, marris) === 7	2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Mary Lillian Carrill	4	17	2006	845 AM
	Examin	er	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Deat	h 4c. Count		
		e	Julia Manor Health Care Center Hagers			Washi	
	Funeral		1 M 2 XF	8. Date of Bir (Month, Da	ay, Ye <i>ar)</i>		ace (State or Foreign ry)
	Director		557-24-9460 1 84 Yrs.	March 2:	2,1922	Indi	ana
	pue 🗼	ŀ	10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	Maryl Sh	5	Md. Washington Hagerstown				1 ☐ Yes 2 🕅 No
	188 the 1	2	Md. Washington Hagerstown 10e. Street and Number 10f. Zip Code		10g. Citizen of	What Count	ry?
	E o K		13224 Glendale Rd. 21742			U.S	2\
	ould be filed within 72 hours effer death with the Marylend Mantal Hygiene. Rickd other than "natural", or items 23a or 28a-f show atic event, the Medical Exerciter must be notified at	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No	o- 14. Ra	ce - America	ın Indian,
2	le le le le le le le le le le le le le l		1 Never Married 2 Married 1 A Yes 2 No 1 1 No 1 No 1 No 1 No 1 No 1 No 1	Hican, etc.)		ack, White, e	
7	alt, o	þ	If Yes, Give 41-46 1 ☐ Yes 2 🖾 No Specify: Year or Dates:		Speci	ry:	White
ה ה	72 ho	Be Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin (life. DO NOT use retired)	ing	16b. Kind of E	Business/Ind	ustry
V	Hi e Hi	ם	Elementary/Secondary (0-12) College (1-4or 5+)				
V	ygier Agier f. fr	S	17. Father's Name (First Middle Last) 18. Mother's Name	/Fire A & Sindalla	Maidan Cuna		ome
	d day	Be	77. 14.0.0 5 14.11.6 (7.10.1, 7.10.1)			me)	
2	should and Man marke umartic	2	THOMAS DOSEDIE HOOD	ian Sch		Ctata 7in	Code
maryiana z i z i 3-0020	12 sh and len		19a. Informant's Name/Relationship (Type, Print) Sally A. Lay (Daughter) 19b. Mailing Address (Street and Number or Rura P.O. Box 153 Smithsburg			1, 31 a 10, 210	C00e)
	1 and Health im 27 ther tu		20b Place of Disposition 20b Place of Disposition (Name of	Date	20c. Location	- City or Tox	vn. State
aitimore,	Pages nent of h int: if ite		cemetery crematory or other place)				
	rtant rtant		4 Donation 5 Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	pril. 8,2006	Smiths	burg,	Md.
מ	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene. Department of the m27 le merked other than "natural", or ferms 28a or 28a-f show eny injury or other treumatic event, the Madical Examiner must be notified at once.				2525 Bra		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	Home Sn	nithsbur	g,Md.	Approximate
	HO UE		shock, or heart failure. List only one cause on each line.	or respiratory e	a1103t,	1	Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition a. Dementia			-	
	Examiner					- 1	
Ç	*	ē	Due to (or as a consequence of):				
	utad d ansit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Hypothyroid 'S'M Due to (of as a consequence of): Ancm, a of chron				
-	exec an an nal-tr	Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C	vic :	Disca	SR	
09/89	te be ysicia ne bu	Ical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			1	
B	ntifica ng ph as th	Med	resulting in death) Last			1	
ROX	The law requires that the death certificate be executed eta has been signed by the attanding physician and page 2 should be detached for use as the burial-transit		d				
	e dea the at ned fo	by Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	l tobacco usa c	ontribute to	tha causa of death?
7	at the	된		1 🗆	Yes 2□ No	3 Prob	ably 4 Unknown
Records, P.O.	res th signer	Ď		Ode Wes		24h Wa	re autopsy findings
5	een s	ž			s an autopsy formed?	ava	illable prior to
ပ္	law las b	ם		0700	,	of c	leath?
=	The seta i	Completed		13	Yas 2UNU	1	Yes 2 No
	Physicien: r this certific rel director,	Be	25. Was case referred to medical examiner? Hospital:				
0	hysion this control	2	1 Yes 2 PNo 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Hor		idence 6 ⊟Ot how injury occu)
DIVISION OF VITAL	Ing P	io	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work?	200. 2000120	Thou injury cook		
<u>s</u>	Attending ir death. ector: After by the fune	cat	3 Suicide 6 Could not be one of laive, At home farm street fector, office	28f. Location	(Street and Nun	ber or Rura	l Route Number,
⋛	or Al aftar Direc in by	Certification:	4 Homicide determined building, etc. (Specify)	City or To	own, State)		
_	To the Hospital or Attending Physicien: The law within 24 hours aftar death. To the Funerel Director: After this certificeta has complately filled in by the funerel director, page 2.	Č E	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the	e cause(s) and n	nanner as st	ated.
	E Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time	, date and place	, and due to	the cause(s)
	o the	Me	29b. Signature and title of certifier 29c. License number	,	29d. Date sign	ed (Month, I	Day, Year)
	172		Jaid mucher 106039	76	04/1	710	6
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	al	ct	- L	
	IVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 00	1	sh m	D 1	1740
· 5	Sta	te	31. Date filed (Month, Pay Year) 9 2006 32. Registrar's Signature	124)		- 1
	Registr	ar	MER I U CUUO MARCEN D. PEPRANTI				

			For State Registrar	State of N	Maryland		rtment o			ind M	lental Hyg	iene		381	6
			1. Decedent's Name (First, Middle,	Last)							2. Date of Deal	th Day	Year	3. Time of	Death
	Physicia /Medic			Rev. John	J. Con	my, O.	S.F.S.				April	21	2006	1215	РМ
1	Examin	er	4a. Facility Name (If not institution,	give street and number	er)		4b. City, Tov		_ocation o	f Death			y of Death		
		•	Annecy Hall	Cay 7	Ann /In um Ir	not highday)	Chil ff Under 1 Y		If Under 2	A Hrs	2 Data of Birth	Cec		la /Ota ta	. C/
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Mm 2 F 95 Yrs.									Hours	Min.	8. Date of Birth Month, Day, OCT 12,	Year) 1910	Pen	lace (State of try) nsy1va	nia Inia
			Usual Residence of Decedent								001 12,	1710	1 011	1157110	
	arylan show	_	10a. State 10b. County			, Town or Lo	cation						1	0d. Inside Cit	
	Be-f s	ecto	Maryland Ceci	1	Ch	ilds	1							1 🗌 Yes	2 XNO
	with ti	<u>i</u>	10e. Street and Number	D 1			10f. Zip Co				1	0g. Citizen of		-	
	eath	eral	1120 Blue Ball 11. Marital Status	12. Was Decede	nt Ever in II S	S 13 V	Vas Decedent		nanic Orio	nin? (Sne	ocify Ves or No-		d Sta		
(0	r Itan	Funeral Directo	1 Never Married 2 Married	Armed Force d 1 ☐ Yes 2	s?	l.				, Puerto	ecify Yes or No- Rican, etc.)		ck, White,		
8	ral', o	l by	3 Widowed 4 Divorced	If Yes, Give 1 Year or Date	_	1	□Yes 2【X	No	Specify:			Speci	^{fy:} Wh	ite	
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an	ld be ental ked o	To Be	Bartley Conmy						Cath	erin	e Loftu	S			
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	and 2 salth an 27 i	7	Oblates of St. Fr	ancis de Sa						ay,	Wilming	ton, D	elawa	re 1980	06
Baltimore,	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	B⊟Removal from Sta	20b. Pl	ace of Dispos emetery, cren	sition (Name of natory or other	of r place)) A	pri	26,	20c. Location	- City or To	wn, State	
Ë	t Pag tment ant:		`4 ☐ Donation 5 ☐ Other (Spe	ecity)	ОЪ		Cemeter	-		2006		Childs			
Ba	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23a or 28e-f show any injury or other traumetic avant, the Medical Examination to other traumetic avant, the Medical Examination of the notified at once.		21. Signature of Funeral Service Lie	8. Hicko	2	Hi 10	Cks Ho	ddress me toc	for I kton	Fune Str	rals, P. eet, Elk	A. ton, M	lary1a	nd 219)21
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus nly one cause on each	sed the death n line.	. Do not ente	er the mode of	f dying,	such as	cardiac c	or respiratory arre	est,		Approximate Interval Betw Onset and D	ween
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_a ab	domi	w/ 0	write	Ö.	new	45r	n rup.	wc		30 4	ENS
	/Medical Examiner		resulting in equally		as a consequ	1	10		1.	1	- 1				Sec
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ord G	w require been sig should b	ted									1 ☐ Ye	s 2 10	3 🗌 Prob	ably 4 □U	nknown
Record	has be	Completed									24a. Was ar autops		Were autop	sy findings a	available ause of
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o	Phys r this ral dri	- To	1 Yes 2 No	28a Date of Ir		ER/Outpatient 28b. Time of			4 □ Nur		ne 5 Aeside 28d. Describe ho	nce 6 Oti)	
O	nding th. : After s fune	tion	1 Natural 5 Pending 2 Accident investiga	(Month, L	Day Year)	Injury		Injury a Work?	es 2□N			, ,			
Division of	Attar or dea ector by the	ifica	3 Suicide 6 Could no determine	ed 286. Place of	Injury - At hor	me, farm, stre	et, factory, of	fice		2	28f. Location (Sti		ber or Rura	Route Numb	ber,
Ö	tel or rs afte al Dir	Certification:	4 Hollicide	bullding,	etc. (Specify)	,					City or Town	, State)			
	To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying (Check only one) 1 Medicel Ex	Physicien: To the be teminer: On the basis and manner	of examinati	vledge, death ion and/or inv	occurred at the estigation, in r	ne time my opir	, date and nion, deat	place, a	and due to the ca ed at the time, da	use(s) and mate and place,	anner as stand due to	ated. the cause(s)	
	To th within To th comp	Me	29b. Signature and little of certifier	12 11 11					number			d. Date signe	ed (Month, L	Day, Year)	
			(hi (1)	C. Hal	-, Pc	<u>). </u>	C	2 -	- 00	05	256	April.	25,	2006	
	10		30. Name and address of person who Christine E. K	no completed cause o	of death (Item	11.01			Pla		Werder	, ,	10	vc 191) //
						F 5	Section N	100	1 "		1000-		· www	11	1 11

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Bruce H Spring

32. Registure s Signature

2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Douglas 5:00 A M 2006 April 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing and Rehabilitation Center
5. Social Security Number 6. Sex 4 7. Age (In yrs. last birthda) Berlin Worcester If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year)

9-12-2 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 AF Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Worces (Omoke 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 8 Was Decedent ever in U.S. Armed Forces? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 The lif Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tiled within 72 Department of Heelth and Mental Hygiene. Important: if Item 27 le marked other than "ne any Injury or other traumatic event, the Medici one. Elementary/Secondary (0-12) College (1-4or 5+) Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cleola Henr 20a. Method of Disposition Date Oc. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Shilol 4 □ Donation 5 □ Other (Specify) enctary 22. Name and Address of Facility Bennic Sm 21. Signature of Funeral Service Licenseev P.O. Box 331 POCOMOK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular 3 months accident **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physicien and debedetached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown cete hes been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 24a. Was an autopsy performed? certificete 1 Yes 2 1 No of Vital within 24 hours after death.

To the Funeral Director: Áfter this certitic completely tilled in by the tuneral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital 1 Cartifying Physician: To the least of my knowledge, death occurred at the tinie, date and place, and due to the cause(s) and normal as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number (0E) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C1-0006795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRIFFIN HIGHWAY, FEMMUK ISLAND, DE 19944 MO 1209 CONSTAL 31. Date filed (Month, Par egistrar's Signatur 32. State 2006 Registrar

			For State Registrar	State of Marylan		artment rtificate			nd Men		giene	06	13819	
Ng.	ta type	2.5	Decedent's Name (First, Middle, La	st)					2. (Date of Dea	ith		3. Time of Death	-
all.	Physici /Medic	-	LaRue Frances D	OMARUK					A	Month	Day	2006	5:45 PM	
	Examir	-95	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Te	own, or Lo	ocation of	Death		4c. Co	unty of Death	1	_
		2	Washington Coun				erst	own	4 Hea Tare		Wa	shingt	on	_
e lu	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. □ M 2127 F 86	last birthday, Yrs.	If Under 1 Months		f Under 24 Hours	Min. (Date of Birth Month, Day	, Year)	Col	place (State or Foreign untry)	
,c	Director		217-12-1875 Usual Residence of Decedent	00					Ma	rch_2	1_191	9 Ma	ryland	_
	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow he Madigal Exercitive roust be maiffed at		10a. State 10b. County	10c. Cit	y, Town or L	ocation						1	10d. Inside City Limits	
	Ba-f	Director	Maryland Washin	gton	Hager								1 ☐ Yes 2√ No	_
	with th		10e. Street and Number			10f. Zip C	Code				10g. Citizen	of What Cou	untry?	
	eath v	Funerai	536 Beaver Creek 11. Marital Status	Road 12. Was Decedent Ever in U	S 13	Was Decede	1740	anic Origin	in? (Specify	Yas or No.	14	USA Race - Amer	ican Indian	_
	tter d	F	1 Never Married 2 Married	Armed Forces?	.0.	If Yes, specif	fy Cuban,	Mexican,	Puerto Rica	in, etc.)		Black, White		
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 🎇 Divorced	1 ☐ Yes 2 ₹ No If Yes, Give ↑ Year or Dates:		1 □ Yes 2)	No .	Specify:			Sp	ecify: Wh:	ite	
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Maryland	d be sental	To Be	James W. Settles						ah Law			,		
37	shoul nd M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and				r, City or To	own, State, Z	ip Code)	_
	alth a		Michele Stevens	- Daughter	536	Beaver	Cre	ek Ro	oad H	agers	town.	Md. 2	1740	
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Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Special		ersto	wn Cre	mato	ry 4	/17/0	6	Hager	stown.	Maryland	
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	40 E 9 9		Cott	11/cense		15 E.				_		, Md.		
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g-1.	Physician /Medical		disease or condition resulting in death)	a. ACUTE Due to (or as a conseq		ALF	AIL	UFE						_
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٣.	s that ned b a deta	by Pt	Part II. Other significant conditions		•	, ,				23e. Did to	bacco use	contribute to	the cause of death?	
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uc	ding l h. After funer	tion	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	Injury	M 28	lc. Injury a Work?	s 2 □Ne		Describe ii	ow injuly of	ccurred		
Division of Vital Records,	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At h	ome, farm, st				28f.			umber or Ru	ral Route Number,	-
2	after Dire	Certification:	4 Homicide	building, etc. (Specia	(y)					City or Tow	n, State)			
	To the Hospitel or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as it	Medical C	29a. Certifier Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, dea ation and/or in	th occurred a nvestigation, i	t the time, in my opin	date and lion, death	place, and occurred a	due to the o	ause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)	
	To the Within To the comple	₹	29b. Signature and title of certifier				License n			i		igned (Month		-
	->		* (V61)_			D	100	623	27		4/1	15/1	6	
			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	, Print)	4	0	7:7	1 1 10				
51	4-5		368 MILL			MM,	, m	()	217	40				
488	Sta Regist		31. Date filed (Month, Day, Year) APR 182	32. Registrar's Signa	ature	mante d								

DHMH 17 Rev 1/2001

ORIGINA

			For State Registrar		State	of Maryla	•			ealth a Death	and M		giene Reg. N o.	006		3820
ı			1. Decedent's Name (First,	Middle, I	Last)							2. Date of De.	ath Day	Yea	ar	3. Time of Death
н	Physici /Medic		Conant	J	Η.	Emmor	ıs					April_	15	200		4:00 P M
	Examin		4a. Facility Name (If not ins	titution, g	give street and n	number)		4b. City	, Town, or	Location o	f Death		4c.	County of D	eath	
ūr.			Northampton	Mano	or Nursi					ederi				Frede		
	Funeral		5. Social Security Number	6	.Sex 1⊠M 2□F	7. Age (In yr	s. last birthday)	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	v. Year)	9.1	Birthpl Count	ace (State or Foreign try)
	Director		224-60-6368			96	Yrs.					July 8,	190)9 W	ash	ington, DC
	and *		Usual Residence of Deced	County		10c. 0	City, Town or Lo	cation							10	Od. Inside City Limits
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	28a-	Director	10e, Street and Number	rede	LICK	L	rie	-	p Code				10a. Citi	zen of What	Coun	irv?
	With Sa or		2088 E. Gre	en1e	af Drive	e			2170	2				Unite		
	death ms 2;	Funeral	11. Marital Status	CILLO	12. Was De	ecedent Ever in	U.S. 13.	Was Dec			gin? (Spe	acify Yes or No Rican, etc.)	.	14. Race - A	merica	an Indian,
0	after of	표	1 Never Married 2] Marriec	Armed I	2 ☑ No					, Puerto	Rican, etc.)		Black, W		
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Maryland 21215-0036	12 sh and rem		19a. Informant's Name/Re									il Route Numbe				
a) a)	1 end Healtl am 27		Patricia Mc 20a. Method of Disposition	Henr	y / Dau		2088 Place of Dispo			eaf D		Frede		cation - City	-	nd 21702
Baltimore,	or or		1 ☐ Burial 2 🖾 Crem			m State	cemetery, crei	matory or	other plac	' E	Apri.	1 19,				
<u>=</u>	t. Pa rtmer rtant njury		4 Donation 5 0			Fr	ederic					2006				laryland
Ba	permit. Pages 1 end 2 should be Department of Health and Menta Important: If item 271s marked any injury or other treumatic ev once.		21. Signature of Funeral S	SIVICE LIC	ensee							uffer I				
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		-	Sequentially list conditions	ė	b. Due t	o (or as a conse	equence of):		7000						177	pears
	uted Insit		if any, leading to immedial cause. Enter Underlying Cause (Disease or injury	- ≺											1,	
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œ		ο̈́										perfo 1 ☐ Yes	rmed? 201 No	death	h?	2 No
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<u></u>	Physician: r this certific ral director,	2	1 ☐ Yes 2 No				☐ ER/Outpatier			4 X Nui	rsing Hor	me 5 🗌 Resid	dence (3 □Other (S	Бр ө сіfу)
u u			27. Manner of Death 1. Natural 5	Pending	28a. Dat (Mo	te of Injury onth, Day Year)	28b. Time o Injury		28c. Injun Work			28d. Describe i	now injur	y occurred		
Division of Vital Records,	tendi leath. tor: A the fu	cat	2 Accident	investigat Could no	1			М	1 🗆 '	Yes 2 1						
Ë	if or Attend after death Director: , d in by the f	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determine	289. Pla	ce of Injury - At Iding, etc. <i>(Spe</i>	home, farm, str cify)	reet, facto	ry, office		1	28f. Location (S City or Tox	Street an vn, State	d Number oi)	r Rurai	Route Number,
	urs al urs al urs al		NA -													
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	(Check only 2 M	ertifying edical Ex	Physician: To t caminer: On the	basis of exami	nowledge, deat nation and/or in	h occurre vestigatio	d at the tim n, in my o	ne, date and pinion, deat	d place, a th occurr	and due to the ed at the time,	cause(s) date and	and manner place, and	r as sta due to	ated. the cause(s)
	the	Med	one) 29b. Signature and title of	certier	1	anner stated.		2	c Licens	a number			29d Dat	e signed /M	onth (Dev Year)
	Z Z Z		255. Signature and third of		7				01	300	1		4	1-17-	-00	5
, -			70 No.	-				Dei	174	/0 /	1					
12			30. Name and address of p		no completed ca	tuse of death (It	em 23a) (Type,	1 DZ	14	SULL	- 1	1 re	B	Len	· L	M
	Sta	te	31. Date filed (Month, Day		32.	. Registres Sig	nature ,		W1 -	,,,,,,	- / 1	/	,			
	Registr			APR	1 9 2006	Medi	w B	40	ever)							

			For State Registrer	State of Maryland		artment of Hertificate of D		nd Men		ne 2.006	13821		
3	y " - E		Decedent's Name (First, Middle, Last)						ate of Death		3. Time of Death		
	Physicia /Medic		George W. G	reenville				Ar	oril 14	2006 Year	10:05A M		
	Examin		4a. Facility Name (If not institution, give sti	reet and number)		4b. City, Town, or	Location of D	Death		4c. County of Dea	th		
110	SHR.		Montgomery Gene 5. Social Security Number 6. Sex		hinton a	01ney	If Under 24	Hrs. o. F	No. of Dist	Montgon			
	Funeral Director			7. Age (In yrs. last	Yrs.	Months Days		Min. (Date of Birth Month, Day, Yo V. 3, 1	ear) C	thplace (State or Foreign ountry) SSOURI		
*	D		Usual Residence of Decedent					_NO	v. J, I	720 HI	550011		
	anylan show d at	ų.	10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits		
	8a-f	Directo	Maryland Montgome	ry D.	amasc						1 □ Yes 2 □ No		
	with th	Dir	10e. Street and Number			10f. Zip Code			10g.	. Citizen of What C	-		
	ns 23	Funerai	25300 Woodfield 1	2. Was Decedent Ever in U.S.	13. \	208 Was Decedent of His		n? (Specify	Yes or No-	U.S.			
0	r then	Fun	1 ☐ Never Married 2 Married	Amed Forces? 1 X Yes 2 □ No	1	Was Decedent of His I Yes, specify Cubar		Puerto Rica	n, etc.)	Black, Whi			
9	ref, o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1945–4	7	1 ☐ Yes 2 🛣 No	Specify:			Specify: W	hite		
21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Tarked other than "naturel", or items 23e or 28e-f show after event, it a Medical Examera mination multiple at	Completed	15. Decedent's Educa (Specify only highest grade		(Give	ient's Usual Occupa kind of work done d	uring most of	f working		b. Kind of Business			
12	within then then	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) 1facturers		esent					
d 2	filed Hygie Sther ent,	CO	17. Father's Name (First, Middle, Last)							iden Sumame)			
Maryland	id be entai ked c	To Be	William T. Gree	nville, Sr.			Cat	herin	e Wal	ker			
ary	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene a and Mental Hygiene is marked other than "naturel", or thems 23a or 28a-f show aumatic event, it a Madigal Exam and must be marified at	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	g Address (Street a	nd Number	or Rural Ro	ute Number, C	ity or Town, State.	Zip Code)		
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		Patricia Greenvill		-) Woodfie			amascus	, Maryla	nd 20872		
u	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re			sition (Name of natory or other place		Date		c. Location - City or			
Ĕ	Pages tment of I tant: if its jury or o		4 □ Donation 5 □ Other (Specify)	Metr							ia, Virginia		
Ball	permit. Pages Department of H Important: If ite eny injury or of once.		21. Signature of Runeral Service Libenset	lliams	Mc 26	Name and Addres lesworth-	s of Facility -Willia - Road	ams P	.A., Fu	neral Ho	ne d 20872		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onest and Death Onest and Death										
	Physician		Immediate Cause (Final disease or condition	Strok	e						Onset and Death		
-	/Medical Examiner		resulting in death)	Due to (or as a consequen	ce of):				*				
* 1	LAGITITICI	_	Sequentially list conditions, b.	Due to (or as a consequen	ce ol):								
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Data to (or as a consequent	00 01).								
,	execun and undial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a consequen	ce ol):								
760,	ate be executed hysicien and the burial-transit	icai	d.										
	ntifica ng ph as th	Jedi	IF FEMALE:							1			
Box	death certifica e attending pt ed for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	 Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 	ath 3	Ectopic pregnancy				23d. Date of de Month	livery Day Year		
0	the al	/sici	1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	າ 5⊡	Other (specify)				Nonin	buy Tou.		
<u>.</u>	that the de ed by the a detached t		Part II. Other significant conditions conti	ibuting to death but not resulting	a in the ur	nderiving cause give	in in Part I.		23e. Did tobac	co use contribute I	o the cause of death?		
Records,	S C 0	d by	Diahetes		•	, , , , , , , , , , , , , , , , , , , ,			1 🗆 Yes	2) √ 6 3 □ P	robably 4 Unknown		
Sor	w require been signature should t	Completed	71200					_ -	24a, Wasan	24h Were a	utopsy lindings available		
Re	The taw ete has page 2 :	dmo						_	autopsy performe	d? prior to death?	completion of cause of		
<u>a</u>	iicien: Th certificete rector, pag	Be Co	25. Was case referred to medical				26 Place of		1 Yes 2	No 1 ☐ Ye	s 2000		
<u> </u>	Q 50	To B	examiner?	spital: 2 ER	/Outpatien	t_3 DOA Othe	-			e 6 Other (Spi	ecify)		
Division of Vital	ng Ph fter th neral		27. Manner of Death 1 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. Injury Work	at ?	28d.	Describe how	injury occurred			
Sio	Attending ir death. ector: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be				res 2□No						
\leq		Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office			ocation (Stree City or Town, S		lural Route Number,		
	Hospital or 24 hours afte Funerel Dir tely filled in	Ce	29a. Certifier Certifying Physic	cien: To the best of my knowle	dge death	a occurred at the tim	o date and r	nlace and (due to the caus	sa(s) and manner a	c stated		
	e Hos 24 h Fun e Fun	edical	(Check only 2 Medical Exemine one)	er: On the basis of examination and manner stated.	and/or in	vestigation, in my op	inion, death	occurred at	the time, date	and place, and du	e to the cause(s)		
	To the Hospital within 24 hours and to the Funerel completely filled	Me	29b. Signature and title of certifier			29c. License	number		29d.	Date signed (Mon	th, Day, Year)		
)) ///// (1)	IN MD		100	6316	9	41	14/0E	>		
7			30. Name and indress of person which	pleted cause of death (Item 23	la) (Type,	Del-10			A)	1.15			
			Hatthew Highd	ven 18101	Pr	iver ph	lip D	NINC	CINA	y, MD	20837		
1	Sta Registr	ite ar	31. Date filed (Month, Day, Year) APR 1 9	2006 Signature	K	Smiles	•			,			

Please Type or Print in Black Indelible Ink

nomas Lopez F	_	1- For State		ertificate of		nd Mental I	R	eg. No.	6 1382	
Physicia Medical Examir		1. Decedent's Name (First, Middle,t	Last)Thomas Lopez I	Tugimori Conza	lez		2. Date of Dea Month April 22, 2	Day Year	3. Time of Death 1155 hrs	
		 Facility Name (if not institution, 4612 Greenwood Road 	give street and number)		4b. City, Town, o Beltsville	r Location of Dea	ath	4c. County of Dea Prince Georg		
Funeral Director		none	Sex 7. Age (in yrs 3 6	last birthday) Yrs	If Under 1 Year Months Day			/1970 Fore	irthplace (State or	
Maryland 28a-f show any d at once.	_	Usual Residence of Decedent 10a State 10b. County Prince	e George's	ty, Town or Locat Hyatts	ville				10d. Inside City Limits 1 Yes 2 X No	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 5404 20th Av	renue	_	10f. Zip Code 2078	2	1	10g. Citizen of What Country? Mexico		
after death wi	by Funeral	11. Marital Status 1 X Never Married 2 Marr 3 Widowed 4 Divorce 15. Decedent's Education (Specify	1 Yes 2 No	1 X	as Decedent of Hi res, specify Cuba res 2 No nt's Usual Occupa	n, Mexican, Puer specify: Me	xican	White, etc. W Specify:	nican Indian, Black,	
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exan	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	employe	e. DO NOT use re	etired)	16b. Kind of Business/Industry none		
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Jose Lopez Hernandez 17. Father's Name (First, Middle, Last) Jose Lopez Hernandez 18. Mother's Name (First, Middle, Last) Erpidia (nzalez Lo	_	
MD 21 rd 2 should fith and Me m 27 is ma aumatic ev	٩	19a Informant's Name/Relationship Susana Vasque	ez/Cousin	5404	1 20th	Avenue	r Rural Route Nur Hyatts	mber, City or Town, States Sville, Mo	e, Zip Code) d 20782	
Baltimore, permit Pages I and Department of Heal Important: If iten migney or other tra	1	 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spece 	3 Removal from State	o. Place of Dispose crematory or other contract of the contrac	sition (Name of ce her place) Munic	ipal 5,	Date / 0 4 / 0 6	20c. Location - City of Tlaxcala		
		21. Sign the of Funeral Service Line 1	ldr"						CE,P.A. ng,Md20910	
Physician /Medical Examiner	1	23a Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	a Complication	s of Chro			or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death	
The said	-e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence b. Due to (or as a consequence							
ted J Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence d.	of):						
760, freate be executed g physician and the burial - transit	Medical		X AMENDEDitem#1,23	Ba,27,perM	E,G856,6/6	5/06 TT				
. Box 68761 ne death certificate rithe attending phy hed for use as the b	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcome of pre	2 Fe	etal death 3 ther (Specify)	Ectopic preg	nancy	23d. Date of delive Month	ry Day Year	
ires that the displaying signed by the	by Phy	Part II. Other significant condition	ns contributing to death but not	t resulting in the u	underlying cause	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?	
cords law requ	Completed						24a. Was autop perfo 1 🗸 Yes	psy prior to med? death?	utopsy findings available completion of cause of	
Vital Reco ysician: The la his certificate ha director, page 2	8	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		Other Nurs		Residence 6 V Other	or Soons	
ion of Vital Rectending Physician: The eath corr. After this certificate the funeral director, page	ition: To	1 V Yes 2 No 27. Manner of Death 1 X Natural 5 Pendin	28a. Date of Injury (Month, Day,Year)	28b. Time of I	Injury 28c. Inju	ury at Work?		how injury occurred	or ocene	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ertification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	28e. Place of Injury - At	home, farm, stree	et, factory, office	building, etc.	28f. Location (S or Town, S		ural Route Number, City	
To the Hosp within 24 ho To the Fun completely i	Medical C		sician: To the best of my knowle ner: On the basis of examination and manner stated							
F % F %	ğ	29b Signature and title of certifier	YG)		29c. Licen: O.C.	se number		29d. Date signed (Me April 23, 2006	onth, Day, Year)	
		30. Name and address of person with Ana Rubio MD. Assis	no completed cause of death (Ite tant Medical Examiner		Street, Baltim	ore, MD 212	01	•		
Sta Regist	ate	31. Date filed (Mon Depy or)	2006 32. Registrar's Signa	ature	reles			· · · · ·		

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CRAHAM **Physician** YLTON Month Year -50 AM 2006 /Medical 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Jan. 2, 9. Birthplace (State or Foreign Country) New York Days 1**X**1M 2□ F Hours 099-14-9350 91 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Maryland Prince George's Silver Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road, #2121 20904 United States or Items 23e Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 À 1 ☐ Yes 2 No White Specify 3X Widowed 4 □ Divorced natural Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 1-4 Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Graham Mary Lambert ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie A. DiPietro -daughter 5012 Brampton Parkway Ellicott City, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö injury Metropolitan Crematory 4/17/2006 | Alexandria, Virginia ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 any in Lonal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod, of dying, suc as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** cal Theroscheiotza 20118 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 2 No director, 25. Was case referred to medical 26. Place of Death Check onl one) examiner' Hospital: 1 | Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 254 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellij within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 2 29c. License number 29d. Dayte signed (Month, Day, Year) 15+1 10043375 OC Messy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen J. Merritt, M.D. 3160 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year)
APR 18 2006 32. pgistrar's Signature State Colum Registrar

		1 - For State Registrar Amend#23a. F 1. Decegent's Name (First, Middle, Las	State of Maryla	and / Dame		1	ental Hyg	iene) 06	13824
Physic /Med	lical		larie H	'am; / t	On		2. Date of Deat	Pay 2006	
Exam	iner	Doctors Communi			4b. City, Town, or Locat Lanham	on of Death	•	Prince G	
Funera Directo		5. Social Security Number 6. Se		rs. last birthday) Yrs.		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, 10/26/2	Year) 9. Birt	thplace (State or Foreign ountry) veland, Ohio
ryland		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
98a-f•	cto	D.C.		Washing	gton				1 ☐ Yes 2 No
with the a or 2 be as	Funeral Director	10e. Street and Number 4237 Marne Pl., N	T E		10f. Zip Code	019	10	Og. Citizen of What Co	*
to the 23	era	11. Marital Status	12. Was Decedent Ever in	. U.S. 13. V			dy Yes or No-	U.S.A.	
High Ith A 5-0036 72 hours after death with the Maryland "natural; or Iteme 23a or 28a-f ehow citical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married ③ ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates:		Vas Decedent of Hispanic Yes, specify Cuban, Mex ☐ Yes ※☐ No Spec		ican, etc.)	Black, White Specify: Af1	e, etc.
- C - M	lete	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced (Give	ent's Usual Occupation kind of work done during r DO NDT use retired)	most of working	7	6b. Kind of Business/	Industry
nd 2121: ified within I Hygiend within I Hygiend with I hygiend with I hygiend with I hygiend with I have I	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5+)		retary			Meterans Ad	dministration
	Be	17. Father's Name (First, Middle, Last) Nesbit H. Wyn	n	_ Seci	18. M		First, Middle, M	faiden Sumame)	and the second
Maryland 12 should be file 12 should be file 13 smarked oth 17 is marked oth	은	19a. Informant's Name/Relationship (T)				Ruth I.			
_ = = N .		Clarence Scott/So	, , ,		g Address (Street and Nu L St., Seat]				
In core thy timore, Millimore, Millimore, Millimore of Health International of Health International of the support of the supp		20a. Method of Disposition	20b		ation (Name of atory or other place)	Dai		2079	
More altime mit. Page antment of ortant: #		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			Mem. Cem.	4/15/0	6 S	uitland, M	Maryland
Baltimore, permit. Pages 1 a Department of He. Important: if them eny highry or othe		21. Signature of Funeral Service Licens	Prati	22.	Name and Address of Fa H.S.Washing 25 Burroughs	ton & S	ons Co.	,Inc.	
Physician /Medical	a i	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the de ne cause on each line.	ath. Do not ente	r the mode of dying, such	as cardiac or r	respiratory arre	st,	Approximate Interval Between Onset and Death
Examiner and public secured public s	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse	ورب المرابع equence of): una Dise	rtension t- ase	Chron	ve Lo.	4 7 Discose	= 17any y - s.
Division of Vital Records, P.O. Box 68760, or attending Physician: The law requires that the death certificate be exaffer death. Director: After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal déath 3 □i	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
IS, P es that igned t	by P	Part II. Other significant conditions cor				ırt I.	23e. Did toba	acco use contribute to	the cause of death?
ord equire	ted	Deep Venou	5 / hrom	20512			1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Gunknown
Peci e law i has b	Completed	Hnemiq,					24a. Was an autopsy	prior to o	topsy findings available completion of cause of
n: Th		05 W			_		perform 1 Yes 2	ed? death?	2 🗆 No
Vit /siclar s certi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	☐ ER/Outpatient	0		Check only one		
n of g Phy ter this		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at			ce 6 Other (Spec	ify)
Sion tendir eath. or: Af	catic	1 Natural 5 Pending 2 Accident investigation	(month, buy roal)	Injury	Work? M 1 ☐ Yes 2	□No			
Division of Vital Record To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	city)			City or Town,		
he Hosp in 24 hot he Fune pletely fil	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	sicien: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or i <i>nve</i>	occurred at the time, date stigation, in my opinion, d	and place, and leath occurred	due to the cau at the time, dat	se(s) and manner as a e and place, and due	stated. to the cause(s)
To t with To t	Σ	29b. Signature and title of certifier	-		29c. License numbe		290	d. Date signed (Month,	
		put 4	7		D310			4/10/0	6
CK 3		Stuart Turker	14-	em 23a) (Type, P	Green 1	be 14,	WD S	71. Dr. #	430
Sta Registi	ate rar	31. Date filed (Month, Day, Year) APR 1 8 2006	. Registrar's Sign	nature	2				

			1 - For State Registrar		State of M	laryland			of Health and of Death		Reg. No		13825
10 1 g	Physic	ian	Decedent's Name (First, Midd	e, Last)						2. Date of D Month	eath Da	Yook Year	3. Time of Death
	/Medi	cal	Margaret 4a. Facility Name (If not institution		S.	Hale		# 0': T		April			17:25p. M
	Exami	ner				•			wn, or Location of Dea	ith	40	. County of Deat	1
Sec. 1	Funeral		Gladys Spellman 5. Social Security Number	6. Sex	csing Ce	nter ge (In yrs. la	st birthday)	If Under 1 \		s. 8. Date of B	Pr	cince Ge	orges nplace (State or Foreign
	Director		234-40-6536	1 🗆	M 2(X)F	82	Yrs.	Months D	lays Hours Mir	8. Date of B (Month D April	13°,1	923 W.V	A.
pug	≱ 1521		Usual Residence of Decedent 10a. State 10b. County			10c City	Town or Lo	cation					
Aaryli	f sho	ō	,		220								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the	28a-	ect	Md. Prince	e Geo	rge	OXOL	Hill	10f. Zip Co	nde.		10a Cit	tizen of What Cor	
with C	38 or	0	6817 Haven Ave						745		_	J.S.A.	2010 y ?
:1215-0036 within 72 hours after death with the Maryland	ma 2	Funeral Director	11. Marital Status	12	2. Was Deceden Armed Forces	t Ever in U.S	. 13.	Was Deceden	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or N	0-	14. Race - Amer	
after a	or It	Fu	1 Never Married 2 Mar		1 Yes 2 7	No		1 ⊡ Yes 2√2		rto Hican, etc.)		Black, White	
	ural,	d by	3 ☑ Widowed 4 □ Divorced		Year or Dates:			21				Specify: B	lack
72 2	"nat	Completed	15. Deceder (Specify only highe				16a. Dece (Give	dent's Usual O	locupation lone during most of wo etired)	orking	16b. K	ind of Business/I	ndustry
7 12 12	iene.	E O	Elementary/Secondary (0-12)		College (1-4or	5+)		sewife			Н	lome	
ב מ	othe othe	BeC	17. Father's Name (First, Middle,	Last)					18. Mother's Na	me (First, Middle			
ylan ould be	Aenta rked tic e	To B	Henry Smith						Juli	e Ward			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af	E E E	ľ	19a. Informant's Name/Relations	hip (Type	e, Print)		19b. Mailir	ng Address (St	treet and Number or R	ural Route Numb	oer, City o	r Town, State, Zi	p Code)
and and	ealth m 27 nsr tr		Janice Diggs(Da	ught	er)				Ave.,Oxon	Hill,Md	2074	5	
imore Pages 1	or ot		20a. Method of Disposition X Burial 2 ☐ Cremation	3 □Rei	moval from State	cen	netery, crer	sition (Name on matory or other	r place)	Date		ocation - City or T	
E Pa	rtmen rtant: vlury		4 Donation 5 Other (S		1	Res		Mem.G				ewell.W.	
8 8	Department of Health a Important: If item 27 Is any injury or other tra		21. Signal are of Financial Service	7	this		65	Name and A	^{ddress of Facility} Be Branch Av	11 &Johr e.,Temp1	ison Le Hi	Funeral	Home PA
_//\ Ex	ysician and Acadical aminer fransit the prival-transit	l Examiner	23a Farth. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b.	Arter	ioscle a conseque	eratic nce of):		Disease				Interval Between Onset and Death
8/6U	physic the b	dical		d									F 17 - 17 - 17 - 17 - 17
Ords, P.O. BOX 68/6U, requires that the death certificate be executed	attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	230	. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal de	eath 3	Ectopic pregn			2	23d. Date of deliv Month	ery Day Year
T ia	been signed by the s should be detached	y Ph	Part II. Other significant condition	ns contri	buting to death b	out not resulti	ng in the ur	iderlying cause	e given in Part I.	23e. Did t	obacco u	se contribute to t	he cause of death?
rds,	n sign	d by	S/P Cardiac A										pably 4 X Unknown
() ≥	s bee	lete	Respiratory I	'a 1 1 1	ro					24a. Was	20	24h Were auto	opsy findings available
ع ع	ate has page 2	ompleted	Chronic Renal							auto		prior to co death?	mpletion of cause of
		O	25. Was case referred to medical	. rai	Ture				26 Place of De	1 ☐ Yes ath Check only o		1 🗆 Yes	2 🗓 No
		To B	examiner? 1 □ Yes 2√2 No	Hos	spital:	ent 2 EF	VOutpatien	3□ DOA	0:1			G □Other (Specia	50)
n OI	fter th		27. Manner of Death 1 → Natural 5 → Pendin		28a. Date of Inju (Month, Da	iry 28	Bb. Time of Injury		njury at Work?	28d. Describe			7/
SIO Findi	or: A	catio	2 Accident investig	ation					1 ☐ Yes 2 ☐ No				
DIVISION al or Attending	I Direct	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned	28e. Place of Inj building, et	ury - At home c. <i>(Specify)</i>	e, farm, stre	et, factory, off	ice	28f. Location (: City or To	Street and wn, State)	d Number or Rura	al Route Number,
Hospit	To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier 11 Certifyin (Check only one) 1 Medical	Physic xamine	ian: To the best r: On the basis o and manner st	i examination	edge, death n and/or inv	occurred at th estigation, in n	e time, date and place ny opinion, death occu	, and due to the erred at the time,	cause(s) date and	and manner as s place, and due to	tated, the cause(s)
To th	To th	Me	29b. Signature and title of certifier		•			29c. Lic	ense number		29d Date	e signed (Month,	Day, Year)
			Iloth 7	1/1	me			מממ	26024		Anri	1 13,200	16
1	2)		30. Name and address of pers in	vha comp	oleted cause of d	leath (Item 2:	Ba) (Type, F	,	1002		Thit	1 10,200	
- (0			Lester Miles,N	.D.,				,Landov	ver,Md.207	85			
	Sta	1,000	31. Date filed (Month, Day, Year)	HOS .	2. Registr	ar's Signatur	Low	6)	=/20/	101			HINDER TO STATE OF THE STATE OF

			State of Maryland / Department 1- State Registrar Certificate		√lental Hygi	211116	12226
		3	Registrar 1. Decedent's Name (First, Middle, Last)	or Death	2. Date of Deatl	ng. No. UUU	3. Time of Death
	Physici /Medic		Dorothy Madeline Howe		April	13, 2006	6:14P. M
	Examin			own, or Location of Death Minster		4c. County of De Carroll	
	Funeral Director		5. Social Security Number 005-30-2939 6. Sex 1 May 1 M	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, Dec. 23,	1915 Ma	irthplace (State or Foreign Country) ISSAChusetts
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery 10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3c or 28a	al Direc	10e. Street and Number 3128 Gracefield Road, #HS213	Code 20904	10	og. Citizen of What C United S	
030	be filed within 72 hours after death with the Maryland Ital Hygiene id other than "natural", or Items 23c or 28s-f show avant, The Medical Estating frings Let calified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces 2 1 No If Yes, specific Yes, Sive Year or Dates: 13. Was Decedent Ever in U.S. Amed Forces 2 1 Yes 2 No If Yes, Sive Year or Dates:	ent of Hispanic Origin? (Sp fly Cuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	Black, Wh	nerican Indian, lite, etc. White
1215-0036	within 72 ho ene. than "natur he Medicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of	k done during most of work e retired)	king	16b. Kind of Busines Washington A	s/Industry Adventist Hosp.
yland 2		To Be Co	17. Father's Name (First, Middle, Last) Reuben Howe		ne (First, Middle, M Lars	faiden Sumame)	1
Mar	s 1 and 2 should if Health and Men item 27 Is marke othar traumatic	,-		(Street and Number or Rui Chief Road (
Baltimore,	Pages 1 annent of Hea		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or other (Specify)) Ceorge Washing	e of her place) ston Cemetery	I.	20c. Location - City of 2006 Adelph	
Balti	permit. Pages Department of the Important: If ite any injury or of any injury or of the angle.		21. Signature of Funeral Service Licensee Corole Cor	voreBorgwardt	t Funeral	Home, PA	ryland 20705
	Physician		23a. Part 1. Enter the disease, or comunations that caused the death. Do not enter the mode shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition	of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
8/60,	icate be executed physician and s the burial-transit	cal	Due to (or as a consequence of):				5.0
O. Box 68	death certif e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic present 4 Pregnant at time of death 5 Other (specially like) 5 Other (specially like			23d. Date of d Month	elivery Day Year
ς, J	requires that the de neen signed by the a hould be detached f	by	Part II. Other significent conditions contributing to death but not resulting in the underlying car	use given in Part I.			to the cause of death? Probably 4 DUNKnown
Hecord	e law has b	Completed			24a. Was ar autopsy perform 1 Yes 2	prior to	
Vital	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?		th (Check only one		
ō	Phys	on: To		Bc. Injury at Work?	ome 5 Reside	nce 6 Other (Sp w injury occurred	pecify)
DIVISION	or Attending after death. Director; After in by the fune	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	1 Tyes 2 No	28f. Location (Str City or Town		Rural Route Number,
_	ne Hospital or Attending n 24 hours after death. ne Funeral Director: After bletely filled in by the fune	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred a 2 Medical Exeminer: On the basis of examination and/or investigation, i and manner stated.	t the time, date and place, in my opinion, death occur	, and due to the ca rred at the time, da	use(s) and manner ate and place, and di	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signatura and many of certifier MD 29c.	-0054	2/8	0d. Date signed (Mo. 0) 4-14	nth, Day, Year) -06
	.,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Raman B. Kanus, 349 Malc	-0054.	Wern	nintu M	0 21157
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 8 2006 Secure 4	צ			

-	an	Registrar Decedent's Name (First, Middle, La John Stanley Ha	•		rtificate of	o outr	2. Date of Deat Month April	Day	Year 06	3. Time of Death 10:20 a N
Medic amir		4a. Facility Name (If not institution, gi			4b. City, Town, o	Location of Death		4c. County		10:20 a
	48	Washington Adve	•		Takoma				ntgo	
eral ctor		5. Social Security Number 6. 578-18-4500 Usual Residence of Decedent	Sex 7. Age (In yrs. la 1 M 2 F 85	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 21	, 1920	Cour	place (State or Foreigntry) nington, [
tified at	ctor	10a. State 10b. County	George's	Town or Lo	ocation ttsville				1	0d. Inside City Limits 1 ☐ Yes 2 No
De no	i Director	10e. Street and Number 1415 Torrey Pla	ce		10f. Zip Code 2078	.2	11	0g. Citizen of USA	What Cour	ntry?
any injury or other traumatic event, the Medical Examinar must be notified at page.	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWI		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rac Bla	ce - Americ ck, White,	etc.
Medical	Completed	15. Decedent's Elementary/Secondary (0:12)	Education rade completed) College (1-4or 5+)	16a. Dece (Give life.	edent's Usual Occup s kind of work done DO NOT use retired	ation during most of work t)	ang	16b. Kind of B	usiness/Ind	dustry
4	Com	Elementary/Secondary (0-12)	Conogo (1 401 51)	Val	ue Engine	er		Federa	ıl Go	vernment
itle event	To Be	17. Father's Name (First, Middle, Las John Stanley Ha				18. Mother's Nam Helen I		Aaiden Suman	n <i>e)</i>	
trauma		19a. Informant's Name/Relationship			ing Address (Street					Code)
or other		Gail M. Hartnett 20a. Method of Disposition 1 K Burial 2 Cremation 3	□Removal from State	ace of Dispo metery, crea	Torrey P1 osition (Name of matory or other place even Cemete:	Apri	Date 18,	20c. Location	- City or To	
any injury		4 Donation 5 Other (Special Signature of Funeral Service Lice	,,,	F	Admens Adre	ss corrivins	Funeral	Home I	Inc.	g, Maryla
cian lical iner	j.	23a. P.In . Enter the disease, or cor strick, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions,	y one cause on each line. a	nance of	1 ort	ery		1		Approximate Interval Between Onset and Death
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ached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3[□Ectopic pregnancy □ Other (specify)	,			ate of deliver	ery Day Year
hed	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3[ath 5[Other (specify)			Мо	onth	Day Year
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page 2 should be detached	Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnan 1 \(\) Live birth \(2 \) Fetal \(4 \) Pregnant at time of dea \(9 \) Unknown contributing to death but not result Hospital: \(1 \) Inpatient \(2 \) E 28a. Date of Injury \((Month, Day Year) \) 28e. Place of Injury - At hone the	death 3 ath 5 ath	other (specify) Inderlying cause give Int 3 DOA Other Int 3 DOA Other Int 3 DOA Injur Wor M 1 DOA Interest, factory, office	26. Place of Deater. 26. Place of Deater. 4 \(\) Nursing Hove the term of t	24a. Was an autops perform 1 Yes 2 th Check only one 5 Reside 28d. Describe ho	Moderate And Number (1, State)	tribute to the stribute to the	Day Year ne cause of death? pably 4 Unknown psy findings available mpletion of cause of 22 No W
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Please Type or Print in Black Indelible Ink

uce Allen How		State of Maryland / I-For State Registrar	Certificate of			Reg	2006	
Physicia edical Exami		1. Decedent's Name (First, Middle, Last) Bruce Allen Howe	<u> </u>			2. Date of Death Month April 21, 20		3. Time of Death 0955 hrs
		4a. Facility Name (if not institution, give street and number) 3164 Benton Square Drive	4	4b. City, Town, or Olney	Location of Death		4c. County of Deat	1
Funeral Director		·	e (In yrs. last birthday) 45 Yrs.	If Under 1 Yea Months Days		_	(MM/DD/YYYY) 9 Bir	thplace (State or gn)
ow any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on Frede	c i o le		· · · · · · · · · · · · · · · · · · ·	10d Inside City Limits 1 Yes 2 YNo
th the Maryland 23a or 28a-f show notified at once.	Director	Maryland Calvert 10e. Street and Number 95 Dares Beach Road	TITHEE	10f. Zip Code 2067		10	g. Citizen of What Cou	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland end 2 should be filed within 72 hours after death with the Maryland end 77 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes Give Yean 9 8	No 1983 1	s Decedent of His es, specify Cubar Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto specify:	Rican, etc.)	14. Race - Amer White, etc	ican Indian, Black,
2036 within 72 hour iene. rer than "natu Medical Exan	ompleted	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5)	5+) during mo	ost of working life	ion (Give kind of v DO NOT use reti	red) er	Building Manageme	
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) William	Howe		18 Mother's Name Barbar	a Jane	Shiff1	
nore, MD 21215-(ages I and 2 should be filed nt of Health and Mental Hyg II: If item 27 is marked oth other traumatic event, the	٢	19a. Informant's Name/Relationship (Type, Print) Tammie Howe/wife	95 D	ares Be	each Rd	. Princ	er, City or Town, State ce Fred.,	MD 20678
imore Pages I nent of H tant: If it		20a. Method of Disposition 1	Cheltenh	ner place) am Vet.	Cem.5/	3/2006	20c. Location - City or Cheltenh	am, MD
Balt permit Departi Import		21. Signature of Funeral Service (Icensee Blacky A. Sewell	14	51 Dare	es Beac	h Kd. F		ed.,MD206
Physician /Medical Examiner		or condition resulting in death) Due to (or as a conse	intoxication an	_		or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Red St.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Due to (or as a consect of the consect of				· ·		
'60, rate be executable strain and the burial - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - trains and - t	Medical	X UNPENDED AMENDED ite	m#23a,27,28a-f	,perME,g85	55,5/10/06	TT		
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcon 1 Live birth 4 Pregnant at 9 Unknown	2 Fe	tal death 3	Ectopic pregna	ancy	23d. Date of deliver Month	y Day Year
P.O.	þ		h but not resulting in the u	ınderlying cause (given in Part I.		pacco use contribute to	the cause of death? bably 4 Unknown
Division of Vital Records, rate death or Attending Physician: The law requires and redeath and Director. After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director.	Completed					24a. Was a autops perforr 1 ✓ Yes 2	y prior to death?	utopsy findings available completion of cause of es 2 No
Vital ysician: his certif director,	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2 ER/Outpatient		of Death (Check Other Nursin		Residence 6 🗸 Othe	r: Scene
ion of Virtending Physicath or: After this the funeral dir	Ε.	27. Manner of Death 1 Natural 5 Pending Fnd 4/21/	(ear)		ryatWork? Yes 2/1X No	28d Describe h	ow injury occurred	
i Pige of Zi	Certification	3 Suicide 6 X Could not be 28e. Place of In	njury - At home, farm, street bund at home	/ TW 1		28f. Location (St	reet and Number or Roate) 3164 Bento	ural Route Number, City n Square Drive
DIVI To the Hospital or within 24 hours after To the Funeral Dir	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner on the basis of examiner.	y knowledge, death occur			due to the cause		
To with To Control	Mec	29b. Signature and title of certifier	4	29c. Licens			29d. Date signed (Mo	onth, Day, Year)
10		30. Name and address of person who completed cause of d Jack Titus MD. Deputy Chief Medical E.	, ,	nn Street, Bal	timore, MD 2	1201		<u> </u>
S Regis	tate trar	31. Date filed (Month, Day, Year) APR 2 6 2005 32. Refistra	ela Cianativa	mell	- 			

		4	1 - For State Registrar	State of M	arylan		artmen tificate			and M		iene _{eg. No.} 0	6	13829
	Physici	an	1. Decedent's Name (First, Middle, Last)		l' A	1.1-11					2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al		Jacque		. Hall	41 02	T	1	(5	Apı	9, 2006	and Daniel	6:05 A M
	Examin	er	4a. Facility Name (If not institution, give s Prince Georg				46. City,	Iown, or	Cheve			4c. Count	•	Seorge's
	Funeral		5. Social Security Number 6. Sex		e (In yrs. I	ast birthday)	If Under		If Under	24 Hrs.	8. Date of Birth			place (State or Foreign
	Director		216-70-7720 ^{1□}	M 3 € F	49	Yrs.	Months	Days	Hours	Min.	(Month, Day Dec 15,		Cou	Maryland
	pug w		Usual Residence of Decedent 10a. State 10b. County	-	10c. City	. Town or Lo	cation							10d. Inside City Limits
	Manyla f sho	ō	MD Prince Ge	orge's					Lando	ver				1 ☐ Yes 2 📉 No
	r 28e	irec	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	intry?
	th with	Funeral Director	7203 East Ridge Drive						2078	5			U.S.A	٨.
	tems	uner	The state of the s	 Was Decedent Armed Forces? 	,	S. 13. \	Was Deced	lent of Hi	spanic Orig	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri ick, White,	can Indian, , etc.
30	rs afte	by F	1 ☐ Never Married	1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	No		1□ Yes	No Z	Specify:			Speci	fy: Black	k
215-0036	2 hou eture ical E	ted	15. Decedent's Edu	cation		16a. Deced	dent's Usua	I Occupa	ation			16b. Kind of E	Business/Ir	ndustry
2	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wor DO NOT us				ng	Poor	d of Ea	lucation
2	be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other then "heturel", or items 23a or 28e-f show other then "heturel", or items 23a or 28e-f show event, the Medical Examinat must be notified at	CO	10 17. Father's Name (First, Middle, Last)				E	sus At	tendant		(First, Middle, I			lucation
lanc	d ta b	To Be		Oscar Watki	ns				10. NIOUTE	i S Name		ther Mac		
Maryland	C1 (0		19a. Informant's Name/Relationship (Ty) Charles Louis Hall/Husban				-				A Route Number	-	, State, Zij	p Code)
altımore,	of Health item 27 other tre		20a. Method of Disposition		1 00	lace of Dispo emetery, crer	sition (Nan	ne of ther plac	e)	C	Date	20c. Location	- City or T	own, State
Ĕ	Pages nent of ent: If it ury or o		Y☐ Burial 2 ☐ Cremation 3 ☐ R ' 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		rnestine J	-		1	04/1	5/06	Chesa	peake	Beach, MD
Balt	permit. Pages 1 Department of H Importent: If ite eny injury or otl once.		21. Signature of Funeral Service License	levell		22		ell Fu	neral H	ome	d Prince Fi	ederick 1	VID 206	578
8/60,	death certificate be executed Wedical Examiner e attending physician and of for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Pue to (or as Due to (or as Due to (or as Due to (or as	a consequence of the death ine.	HEAR Jence of): ARTE Jence of): ENAL Jence of):	TDIZ	ISEA DISE SEAS	such as SE ASE	cardiac c	or respiratory arm	951,		Approximate Interval Between Onset and Death
O. Box 6	the death certific by the attending p ached for use as I	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pro Other (sp						ate of deliv	ery Day Year
ecords, P	law requires that the de as been signed by the a . 2 should be detached f	by	Part II. Other significant conditions con	tributing to death t	out not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did tol	_	tribute to t	the cause of death?
l Heco	The ate h page	Completed									24a. Was a autops perform	у ј	Were autoprior to codeath?	opsy findings available ompletion of cause of
Vital H	Physicien: Th r this certificate rral director, pag	Be (25. Was case referred to medical examiner?	loopitel:				0*	The of the latest and		(Check only on			
0	Physi this c	- To	1 ☐ Yes 2 🕱 No	lospital: 1 Inpati		ER/Outpatien 28b. Time of		8c. Injury			me 5 Reside			(fy)
	Jing Afte fune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	М	Work	ເ?ື່ Yes 2 []i		200. 00001100 110	w injury occu	1100	
Division	I or Attending Physicien: after death. Director: After this certific I in by the funeral director,	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, et	jury - At ho tc. (Specify	me, farm, str	eet, factory	, office		1	28f. Location (St City or Town		ber or Run	al Route Number,
	Hospitel 4 hours Funerel iety filled	edical C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best ner: On the basis of and manner st	f examinat	wledge, death tion and/or in	n occurred vestigation,	at the tim	ne, date an pinion, dea	d place, a	and due to the called at the time, d	ause(s) and mate and place	anner as s	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mainer St	4.64.		290	. License	number		2	9d. Date algne	ed (Month,	Day, Year)
	->-0		1/1/1/2	ne	-	**		03	03	18	-	4/12	100	-3
	سو.		30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,						1-1-		
	15		James Catevenis, M.D.				, MD 2	0785						
	Sta Registr		APR 1 4 2005	N	rar's Signal									

			For State Registrar	State of Marylan		ent of Heal			iene 	13830
	*		Decedent's Name (First, Middle, Last	st)		a.c o. Do.		2. Date of Deat		3. Time of Death
	Physici		Fred	Junior	Н: 1	lebrecht	92	Month	1 S O	OLIGH
1	/Medio Examin		4a. Facility Name (If not institution, give			City, Town, or Loca			4c. County of Deat	0199
	LXamii		SacreDH	18ART HKE	TITAL (Cime	1535	GUA	ALLE	MAG
_	Funeral		5. Social Security Number 6. S	, , ,			Jnder 24 Hrs.	8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign
Ľ	Director		212-14-6232	XM 2□ F 84	Yrs. Mon	ths Days Ho	ours Min.	09/18/1		t Virginia
	D ,		Usual Residence of Decedent	10. 6	T					
	aryta ehov	_	10a. State 10b. County	Toc. Cit	ty, Town or Location					10d. Inside City Limits
	8a-f	octo	MD Alleg	any		nberland				1 X Yes 2 No
	with the	Director	10e. Street and Number	5 1 0	10f	Zip Code		11	0g. Citizen of What Co	ountry?
	s 23	by Funeral	400 High Bed	12. Was Decedent Ever in U	6 40 44 5		502	7 7 7	USA	
	Hem Hem	'n	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	If Yes,	ecedent of Hispan specify Cuban, Me	exican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
36	Ir, or	by F	3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: \[J], [] =		s 2∭ No <i>Sp</i>	pecify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hyglene. titler then "natural", or Items 23a or 28a-f ehow int, the Medical Exama ar must be incitiled at	ed	15. Decedent's Ed	lucation	16a. Decedent's I				16b. Kind of Business/	
75	7 nic 7	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give kind o	f work done during T use retired)	g most of worki	ng		
7	d with	E	12	College (1-401 54)	Busines	s Repres	sentati	ve	Union	
	be file	Be	17. Father's Name (First, Middle, Last)			18.	Mother's Name	(First, Middle, M	Maiden Surname)	
<u>a</u>	should bind Ment	70	Fred	Adam Hil	llebrecht		Sophia	Ros	se	Miller
Maryland	2 shc and le mu		19a. Informant's Name/Relationship (Type, Print)	1				City or Town, State, 2	
	and ealth n 27		R. Patricia Hille						erland, MI	21502
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Items 23a or 28a-1 show with fourly or other traumatic event, the Medical Examination in softies a political and once.		20a. Method of Disposition 1 X Burial 2 Cremation 3	1 ~	Place of Disposition (cemetery, crematory	(Name of or other place)		ate	20c. Location · City or	Town, State
Ē	permit. Pages Department of I Important: If It eny Injury or o		4 Donation 5 Other (Specify	Res					LaVale, MI	
391	Depart Depart Import eny Inj		21. Signatury of Funeral Service Licen	see A						Home, P.A.
	20 7 € a		Kalut (1)	Vely ()					land, MD	21502
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the deat one cause on each line.	Section 1		ch as cardiac c	or respiratory arre	est,	Approximate Interval Between
	Physician	ĺ	Immediate Cause (Final disease or condition	a LIVER	FAILL	RS				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	00	000	mmnn		4 weeks
Н		Ļ	Sequentially list conditions,	b. MSIA	>1 HIC	. 4	TIK C 11	NOMA	- /	4 wers
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence or).					
	and and li-trar	xan	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):					
8760	ficate be executed physician and s the burial-transit	E E			,					
587	ficate phys s the	edical		d						
X	certi nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of deli	verv
m	death a atte d for	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		c pregnancy (specify)			Month	Day Year
0	t the oy the ache	Physician/Me	9 Unknown	9□ Unknown						
'n.	The law requires that the death certifi He has been signed by the attending age 2 should be detached for use as	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	ng cause given in	Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	w require been sig should b	edt						1 □ Ye	s 2⊡No 3⊿Pro	obably 4 Unknown
ပ္က	aw requise been 2 should	plet						24a. Was ar		topsy findings available
Ě		Completed						autopsy pertorm	ned? death?	completion of cause of 2 No
ţ	ian: intifica	Bec	25. Was case referred to medical examiner?			26.	Place of Death	(Check only one	-	
<u> </u>	ding Physician: After this certific funeral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1.21npatient 2	ER/Outpatient 3	DOA Other: 4	☐ Nursing Hor	ne 5 ☐ Reside	nce 6 Other (Spec	city)
_	ding P h. After ti funera	ë.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	1	28d. Describe ho	w injury occurred	
<u> </u>	tendi death. tor: A the fu	catl	2 ☐ Accident investigation		M	1 🗆 Yes	2 🗆 No			
Division of Vital Records, P.O. Box	I or Atten after deat Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ctory, office	1	28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
	pitel ours a srai C		200- 0-446-	 						
	To the Hospitel or Attending Physician: within 24 hours after death To the Funeral Director. After this certification in the funeral director, completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	/sician: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, death occur tion and/or investiga	red at the time, da tion, in my opinion	ate and place, a n, death occurre	and due to the ca ad at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier			29c. License num		200	d. Date signed (Month	, Day, Year)
	11) (1) -	901/					APRIL	8.2006
-	SILVA		30 Name and address of person who	completed cause of death (Item	23a) (Type Print)	1,00 × 0				1
	DIN		Dr. Garnar Za	man 625 k	Kent (Lup	nue C	Lumbé	rland.	Maryla	8,2006 nd 21502
	Sta	te	31. Date filed (Month, Day, Year) APR 1 9 200	32 Registrar's Signa						
1	Registr		APR 1 9 200	b Die	1. Snack	A. A.				

			-	i icase i	State of M											8831
			1 - State Registrar			, , , , , ,				Death			Reg. No.	000		0001
	Dhysis		1. Decedent's Name (Firs	t, Middle, Last)								2. Date of De Month		Yee		Time of Death
	Physici /Medi		Miriam R.									April	14.	2006		3:00 A ^M
1	Examir	ner	4a. Facility Name (If not in							r Location				County of De		
	Funeral		Riderwood 5. Social Security Number				ast birthday)	If Unde	er 1 Year	Sprin If Under	24 Hrs.	8. Date of Bir (Month, Da		lontgon 9. B		State or Foreign
	Director		215-14-804	6	M 2X) F	83	3 Yrs.	Months	Days	Hours	Min.	Apr 16	5, 19	922 N	fary1	
	and W		Usual Residence of Dece 10a. State 10b.	County		10c. Cit	y, Town or Lo	ocation							10d. ln	side City Limits
	Maryl	호	Maryland	Montgon	10 7 37		Silver	Spr	na						1	□Yes 2X□No
	th the or 28s	irec	10e. Street and Number	Honegon	icly		TIVEL		ip Code				10g. Citi	zen of What (Country?	
	ath wi	ra I	3128 Grace						2090				ŲS			
	ter de litema	ne	11. Marital Status 1 ☐ Never Married 2		2. Was Decedent Armed Forces?		.S. 13.	Was Deo If Yes, sp	edent of H ecify Cuba	lispanic Ori an, Mexicai	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-	14. Race - An Black, Wh		dian,
036	ors af	b	3 Widowed 4 D		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			1 🗆 Yes	21X No	Specify:				Specify:	Whi	te
21215-0036	within 72 hours after death with the Maryland ane. then "neture!; or itema 23e or 28e-f show te Medicel Exerciter must be coulfied at	Completed by Funeral Director	15. D (Specify onl	ecedent's Educ	ation completed)		16a. Dece (Give	kind of w	ork done	during mos	st of worki	ng	16b. Ki	nd of Busines		
121	within ane. then	Id III	Elementary/Secondary	(0-12)	College (1-4or	5+)			use retired	•						
	filed Hygid other	Be Co	17. Father's Name (First,	Middle, Last)	4			senoc	от те	acher		(First, Middle		Educati Sumame)	LOII	
/lan	Mental Mental rrked	To B	Isaac Gold	lstein						Celi	a Sa	1tz				
Maryland	2 sho and h ie me		19a. Informant's Name/R	elationship (Typ	e, Print)		19b. Maili	ng Addres	ss (Street	and Numb	er or Rura	I Route Numb	er, City o	r Town, State	, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or itema 23s or 28s-f show any introduced in the marked other than "neturel", or itema 23s or 28s-f show into you other traumatic event, the Medical Experient must be notified at 2005.		Bernard Ho		and	20b. P	312	8 Gra	cefi	eld R		511, Si		Sprin		D 20904
Baltimore,	ages ant of it: if it y or o	,	1 X Burial 2 ☐ Crei	mation 3 🗆 Re	emoval Irom State	C	lace of Disponentery, cred				nr 1	6, 200				own, MD
altir	permit. Pa Departmen Important any injury		21. Signature of Eunera		θ 🕈						_	es-Rina				-
ä	P C L C		Soft			<u>-</u>	1	1800	New	Hamps	shire	Ave, S	Silve	er Spri	ng,	MD 20904
1			23a. Parts Enter the disc shock, or heart failu	ease, or compli re. List only on	ations that cause e cause on each li	d the death ne.	h. Do not en	ter the mo	de ol dyin	ng, such as	cardiac o	or respiratory a	rrest,		Inter	oximate val Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Sepsis											
	Examiner				Due to (or as											
	n =	ner	Sequentially fist condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ate J b	Due to (or as										1	
	ate be executed sysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	٥	Due to (or as	2 2002 200	uanae all:									
760,	be ex sicien burial	cal E	,		Due to (or as	a conseq	derice or).									
89	uficate g phys as the			- 0					-							
Вох	requires that the death certificate een signed by the attending phy hould be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregr	Idiil	lc. If yes, outcome 1□Live birth]Ectopic i	pregnancy	/			2	23d. Date of d	. ,	Year
	ne dea the at thed fo	ysici	in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	15 ?	4□ Pregnant a 9□ Unknown	t time of de	eath 5[Other (s	specify)					Month	Day	1 641
P.O.	that the de led by the a detached t		Part II. Other significant	conditions con	inbuting to death t	out not resi	ulting in the u	nderlying	cause giv	en in Part I		23e. Did t	obacco u	se contribute	to the cau	se of death?
Records,	w requires been sign should be	Completed by	Parkinson'	s disea	se							1 🗆 '	Yes 2[□No 3□I	Probably	4 DUnknown
900		piet	Dementia									24a. Was	nsv	24b. Were	autopsy lir	ndings available on of cause of
<u>=</u>	sician: The law i certificete has b irector, page 2 st	Соп	Atrial fil	rillati	.on							perfo	rmed? 224No	death?	s 2 l	
Vita	Physician: this certific ral director,	Be	25. Was case referred to examiner? y 1 ☐ Yes 2 ☐ No	-	ospital:				Oth	00		(Check only o			. 72	
of	Phy this raid	n: To	27. Manner of Death		28a. Date of Inju		ER/Outpatier 28b. Time o		28c. Injun Wor	4)(_ N(ne 5 Resi			ecify)	
ion	ath. or: Afte	atio	2 Accident	Pending investigation	(Month, Da	y rear)	Injury	М		K? Yes 2 ☐	No					
Division of Vital	or Atte	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of In building, et	ury - At ho c. <i>(Specif</i>)	ome, larm, st	reet, lacto	ry, office		1	28I. Location (a City or To	Street and wn, State	d Number or i	Ru <i>ral R</i> ou	te Number,
Ļ	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 📉 0	Certifying Phys	ician: To the best	of my kno	wiedge, deat	h occurre	d at the tim	ne, date ar	nd place a	and due to the	cause(s)	and manner	as stated	
	n 24 h	Medicai	(Check only 2 N	fedical Examin	er: On the basis of and manner st	f examina	tion and/or in	vestigatio	n, in my o	pinion, dea	th occurre	ed at the time,	date and	place, and di	ue to the c	ause(s)
	To the To the Comp	ž	29b. Signature and title of	certifie	AA	_ /	/ 1/	7) 25	c. Licens	e number			29d. Dat	e signed (Mo	nth, Day, 1	Year)
			•	Folm	SU	WA	US!	30		D236	539		Ap	ril 15	, 20	06
	12		30. Name and address of	. /		•			Q ± 1	***** (In≈i-	o MD (2000/			
	Sta	ate	John H. St 31. Date liled (Month, Da	uckey,	32. Registi	ar's Signa	rure			ver S	prin	g, MD 2	20904	+		
	Regist		APH	(17 20	06	40 4	H A	ask.	9							

		4	For State Registrar	State of Maryland	_	artment of H			giene 06	13832
			1. Decedent's Name (First, Middle, Last)	0 11 1				2. Date of Dea	th	3. Time of Death
	Physicia		Docathy 1-	3011 H	Im.	00		Month April	Day Yea 18,2006	12:10A M
	/Medic		4a. Facility Name (If not institution, give	street and number)	7140	4b. City. Town, or	Location of Death	ADITI	4c. County of De	
	Examin	er								
			Somerdord Place 5. Social Security Number 6. Sec	2100 Whit		Freder If Under 1 Year	rick If Under 24 Hrs.	8. Date of Birth	9.6	derick Birthplace (State or Foreign
	Funeral		1	וא סרדור	Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	Country)
	Director		181-22-7604 Usuel Residence of Decedent	¹ 2X 83				9/8/19	922 P	Α
	and *	i	10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
	aho sho	ō		261						1. Yes 2 □ No
	ле N	ect	MD Frederi	ck Mt	. Ai	10f. Zip Code			l0g. Citizen of What	Country?
	ath with the Marylan 23a or 28a-f show ast be notified at	ä	10e. Street and Number			TOI. ZIP COUG			rog. Citizen or what	Country
	ath v	ā		Cause Court		21771			USA	
	ep .	nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of Hi If Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc.
ထ္ထ	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, I're Medical Evarither installed in	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give X		1 ☐ Yes 2 ☐ No	Specify:		Specify: 1	White
21215-0036	72 hours "natural", dical Exe	d b	3 ☐Widowed 4 ☐ Divorced	Year or Dates:						
ည်	72 h	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of	luring most of work	ing	16b. Kind of Busine	ss/Industry
2	ithin Ban '	id u	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,)			
2	filed w Hygier other th	ပ္ပ	12	2	Н	omemaker			Home	
Maryland		Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u>a</u>	should be and Mental s marked o umatic eve	ည	Simeon Ball				Sarah	Wilkin	son	
E C	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	0 12	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street a	and Number or Rur	al Route Number	r, City or Town, State	e, Zip Code)
	rt 27 ind		Joyce H. VanSar	ıt (Daughter	3320	Heaven1	vCauseC	ourt M	t.Airv.	ra 21771
<u>ē</u>	s 1 au if Hea item othe		·	CO	ace of Dispo	osition (Name of matory or other place	A)	Date	20c. Location - City	or Town, State
2	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F * 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	-			1100		
altimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	Olive	rtie.	rs cemet 2. Name and Addres	s of Facility		arnegie,	
Ba	permit. Departm Importa any inju		David J. Steelle		- 0		Her	shberg	er-Stove	er Inc F.H.
	40244	0.0			and the same of the same of the same of	/U Noble	Ave. Cr	afton,	Pa. 1520	Approximate
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	re cause on each line.	. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arr	0 51,	Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	1/1/2/	hou	mens	alse	200		
	/Medical		resulting in death)	Due to (or as a consequ	ence of):					
	Examiner		Convention to list conditions	,						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):		-			
	uted d ansit	Ē	Cause (Disease or injury that initiated events							
–	exec n an ial-tr	Examiner	resulting in death) Last	Due to (or as a consequ	ence of):		*			
760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical	(1						
.89	ficat p phy is the	edic								
Вох	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar					23d. Date of	delivery
ă	eath atter	ciar	in the past 12 months?	1 Live birth 2 ☐ Fetal : 4 ☐ Pregnant at time of de		□Ectopic pregnancy □ Other (specify)			Month	Day Year
o.	he d the ched	ysi	1 □ Yes 27⊠No 9 □ Unknown	9□ Unknown						
۵.	that the de led by the a detached f	문	Part II. Other significant conditions co	ntributing to death but not resu	lting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Š,	ires tha signed d be det	1 by						1 D Y	es 202 No 3 🗆	Probably 4 Unknown
5	w requir been si should	Completed				-			0/15 33/15	
Records,	has b	ρį						24a. Was a autop:	an 24b. Were sy prior med? death	autopsy findings available completion of cause of
_	Th ate pag	ĕ						perfor 1 ☐ Yes	20 No 1□Y	es 2□No
Vital	Attending Physician: The r death. ector: Atter this certificate hat by the funeral director, page	Be (25. Was case referred to medical examiner?			,,	26. Place of Deat	h (Check only or	ne)	Assectat
	Physic this ce al dire	10	1 ☐ Yes 2 No	lospital: 1 🗆 Inpatient 2 🗆 E	ER/Outpatie	nt 3 DOA Othe	er: 4 🗌 Nursing Ho	ome 5 🗆 Resid	ence GOther (S	pecify)
Division of	g Ph er th eral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury Work	at c?	28d. Describe h	ow injury occurred	
<u>ō</u>	nding I ath. r: After e funer	atio	Natural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Yes 2 □ No			
<u>Vis</u>	or Attendater death Director:	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or	Rural Route Number,
á	i gitte	Certification;	4 - Hornicae	building, etc. (Specify,	,			ony or row	11, 01410)	
	To the Mospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral			sician: To the best of my know						
	B Fu	edical	(Check only 2 Medical Exami one)	ner: On the basis of examinati and manner stated.	ion and/or in	ivestigation, in my op	oinion, death occur	red at the time, o	ate and place, and o	due to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	7//2		29c. License	number	2	29d. Date signed (Mo	onth, Day, Year)
	> - 0		1/1/1/	1/8/ a solit	Han	n D3	518	3 /	Emil.	10 2001
		19	30. Name and address of person who co	omplet d cause of death (Item	23a) (Type	Print)	4	4	1-41	1000
51	4-25		AI. T. AG.	all tola 2	2001	vost 9	h Stom	f The	Mount 1	MD 21701
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	,/	4/10	1110	de l'est	/ /
	Registi		APR 18 20	006	A. 1	parker				
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Registrar

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			State of Maryland / Dep	artment of Health and rtificate of Death	Mental Hygier	71116	13834
		3,	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Audrey Kathleen	Jenkins	April 13	2006	11:15 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death	
			11201 Jon Court	Ijamsville		Frederic	k
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Months Days Hours Min.	(Month, Day, Yea		place (State or Foreign htry)
	Director		216~30~4981 1 93 Yrs. Usual Residence of Decedent		Aug. 10, 1	<u>.912 Maryl</u>	and
	land ow	1	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary I-f sh	į	Maryland Frederick Ijams	sville			1 ☐ Yes 2 ☐ No
	r 28e	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	th wit		11201 Jon Court	21754	τ	J.S.A.	
	r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
36	s afte , or li	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: What	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modical Eraciner must be rollined at	q pa		edent's Usual Occupation	16h	Kind of Business/In	dustry
5	in 72 n "na nedic	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of wo DO NOT use retired)	rking		,
212	yiene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		Own Home	
פַ	2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show eumatic event, the Modical Era ciner must be recified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maid	len Sumame)	
/lar	should be I and Mental I s marked o umatic eve	ToE	Maurice Phillips	Emily	Elsie Jo	ones	
Maryland	2 sho and is mu			ing Address (Street and Number or R	ural Route Number, Cit	y or Town, State, Zij	Code)
	as 1 and 2 should of Health and Men item 27 is marke			l Jon Court, Ija		Location · City or To	
0	ges 1 It of H If ite or ot		1 Burial 2 Cremation 3 Removal from State	matory or other place)			1990 90
Baltimore,	t. Pa rtmen rtent: rjury			Memorial Gardens			
Bal	permit. Pages . Department of the Importent: If ite eny injury or of once.			2 Name and Address of Facility Tolesworth-Willian 26401 Ridge Road,	ns P.A., Fu Damascus,	neral Hom Maryland	e 20872
П			23a. Part1. Enter the disease, or complications that caused the deaty. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	12CS/E/V	OSTS		VIACT
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		,,,		1
	Zxammer	-	Sequentially list conditions, Due to for all a condequence of the conditions of the				/-
-	led sit	nine	cause. Enter Underlying Cause (Disease or injury				
	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of);				
8760,	cate be executed physician and s the burial-transit	dical E	d				
9	the death certificate y the attending phys iched for use as the	ledic					
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant: 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	1
	ne deat the att	sicis	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
P.0	that the di ed by the detached	Phys	9 Unknown		an Bitteberr		t
	Se Gu	by	P. II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		ouse contribute to t 2 □ No 3 □ Prol	\ -
Records,	w require been si should b	ompleted	10 hary 10 1719 12154	m Je		H-1	
ec	2 25 29	n ple	//		24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
	Th ate pag	O			1□ Yes 21		2 No
Vital		o Be	25. Was case referred to medical examiner?	Other	ath (Check only one)	C []Other (C	6.1
of	Phys r this aral di	Η.	1 ☐ Yes 2 ☐ ER/Outpatie 27. M_nner of Death	of 28c. Injury at	d. Describe how in		y)
Division	of or Attending Pater death. I Director: After the in by the funera	tion	ural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Visi	Attendi r death. ector: A by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	treet, factory, office	28f. Location (Street City or Town, St		al Route Number,
ā	s after s after al Direct	Certification:	4 Homicide Building, etc. (Specify)		Ony or Youn, or	4.07	
	To the Hospitel or within 24 hours afte To the Funerel Dii completely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only 2 Medical Examiner: Qn the basis of examination and/or i	th occurred at the time, date and plac	e, and due to the cause urred at the time, date:	e(s) and manner as s	stated. o the cause(s)
	To the H within 24 To the F complete	Medical	one) and manner stated.				
	To To con	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month)	Jay, rear)
	2		More In	טפרטוע		7/17/	V6
	9		30. Name and address of person who completed cause of death (Item 23a) (Type	77 1 1 1	e Mosess 1 am 3		~
	Sta	té	Casper Cline M.D. 300 West 9th S 31. Date filed (Month Pan Year) 7 2000 32. Pysistrar's Signature	street, Flederic	k, Maryland		
	Regist		31. Date filed (Month Par Year) 7 2006 32. Profistrar's Signature	book			

		1 - For State Registrer	ate of Maryland / Depa <i>Cer</i>	artment of Heartificate of De			ene 0 0 6	13835
Physi		Decedent's Name (First, Middle, Last) JEANNIE GRANT	JOHNSON			2. Date of Death Month APRIL	Day Year 15 2006	3. Time of Death 16:45
/Med Exam		4a. Fecility Name (If not institution, give street HOLY CROSS HOSPITA		4b. City, Town, or Lo			4c. County of Death	n
Funera Directo		5. Social Security Number 6. Sex 158−18−5513 1□ M	7. Age (In yrs. last birthday)	If Under 1 Year If		8. Date of Birth (Month, Day,) NOV . 12	(ear) 9. Birth Co. 1926 G€	nplace (State or Foreign untry)
Maryland f ehow	ror	Usual Residence of Decedent 10a. State 10b. County Md. Montgome	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒No
th with the 23a or 28a	Funeral Director	10e. Street and Number 12502 Village Squa	re Terrace #201	10f. Zip Code	20852	100	g. Citizen of What Co United St	•
rs after dea	by Funer		☐Yes 21又No	Was Decedent of Hispa If Yes, specify Cuban, I 1 ☐ Yes 2 ☑ No 5	anic Origin? (Spec Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
ie, will yielly Z.I.Z.I.D.D.D.D.D.D.D.D.D.D.D.D.D.D.D.D.	Completed		16a. Deced (Give ollege (1-4or 5+)	dent's Usual Occupatio kind of work done duri DO NOT use retired)	n ng most of workin	g 10	6b. Kind of Business/l	·
d be filed w antal Hygier ced other th	Be	17. Father's Name (First, Middle, Last)	6 Tea	icher 18	. Mother's Name Helen	(First, Middle, Ma Baldwin		n
Maly nd 2 shout alth and Me 27 is mark r traumati	2	19a Informant's Name/Relationship (Type, F Kathleen Treat / D		ng Address (Street and Homewood				ip Code) 20895
Datumore, permit. Pages 1 an Depertment of Heal important: if item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ Remore 4 ☐ Donation 5 ☐ Other (Specify)	All from State	sition (Name of matory or other place) itan Crem.			oc. Location · City or Alexandria	Town, State , Virginia
permit. Depertrimporte		21. Signature of Funeral Service Licensee Muruf M		Name and Address of Muriel H. P. O. Box				20882
Physiciar /Medica		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	SEPTIC SHOCK	er the mode of dying, s	such as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death 48 hrs.
Examine	r	Sequentially list conditions b	PNEUMONIA Due to (or as a consequence of): PNEUMONIA Due to (or as a consequence of):					1 wk.
icate be executed physicien and sthe burial-transit	edicai Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
Physician: The law requires that the death certifical Physician: The law requires that the death certifical this certificele has been signed by the ettending phyral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
us, T. uires that I signed by	2	Part II. Other significant conditions contribu	ting to death but not resulting in the ur	nderlying cause given i	n Part I.		cco use contribute to	the cause of death?
The law requested has been page 2 shou	Completed					24a. Was an autopsy performe 1 Yes 2	ed? death?	topsy findings available completion of cause of
vican: sician: certific irector,	o Be	25. Was case referred to medical	al: 1 ⊠ npatient 2 ☐ ER/Outpatien	Othor	5. Place of Death	***************************************		
nding Physician: The lath. Ith. r: After this certificete ha	11-	1000	a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work?		8d. Describe how	ce 6 Other (Spec	iny)
To the Hospital or Attending P within 24 hours aftar death. To the Funeral Director. After t completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
Hospi 24 hou Funer etely fill	edicai		n: To the bast of my knowledge death On the basis of examination and/or invented manner stated.	n conurred at the time vestigation, in my opini	data and plane a on, death occurre	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	stated to the cause(s)
To the complex	Me		M	29c. License no	umber 52503	290	1. Date signed (Month	
10		30. Name and address of person who comple SHAILESH SHETH, M.		Print)		R SPRING		
S Regis	itate	31. Date filed (Month, Day, Year) APR 1 8 2006	32. Registrar's Signature	ale				

			For 1 - State	State of Maryla	and / Depa	artmei	nt of H		•	ygien	2006	13836
			Registra MFND#290001MD4 1. Decedent's Name (First, Middle, Last) 00	lliica	e or i	Dealli	2. Date of D	Reg. N	lo.	3. Time of Death
	Physici	ian							Month	D	ay Year	
	/Medi		William Kaiser Ja 4a. Facility Name (If not institution, give			4h Cih	Town	r Location of Deatl	April		c. County of Deat	5:35 A ^M
	Examir	ner							1			
	Euporal		Suburban Hospita. 5. Social Security Number 6. Se.		rs. last birthday)	If Unde	esda r 1 Year	If Under 24 Hrs.	8. Date of B		Iontgomen	hplace (State or Foreign untry)
	Funeral Director			RM 2□F 81	Yrs.	Months	Days	Hours Min.				shington, DC
			Usual Residence of Decedent						riugust	10,	IJZT Was	shington, bo
	nylan Ihow	_	10a. State 10b. County	10c.	City, Town or Lo	ocation						10d. Inside City Limits
	8a-f.8	cto	Maryland Montgome	ry Ro	ckville							1 ∏ Yes 2 □ No
	th with the Marylan 23s or 28s-f show	Director	10e. Street and Number				p Code				citizen of What Co	untry?
	hours after death with the Maryland tural', or Items 23a or 28a-f ahow at Examiner must be notified at	ā	327 Dean Drive			208					J.S.A.	
	er de Item	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	I U.S. 13.	Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	10-	14. Race - Ame Black, White	ncan Indian, e, etc.
지 0036	rs aft		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XIYes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes	2 🔀 No	Specify:			Specify: Whi	lte
7,8	72 hours "natural",	Completed by	15. Decedent's Edu	cation	16a, Dece	dent's Usi	ual Occup	ation		16b.	Kind of Business/	Industry
≥ 0.20		plet	(Specify only highest grad Elementary/Secondary (0-12)	e completed)	(Give	kind of w	ork done i ise retired	ation during most of wor d)	king			,
212	THE R. LEWIS CO., LANSING, MICH.	E	Elementally/Secondary (0-12)	College (1-4or 5+)	Builde	er /	Busi	ness Own	er	Co	nstructi	lon
Z P	be filed tal Hygi d other avant, I	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nan				
- @ <u>F</u>	Mental Mental arked c	To	William Kaiser .	Jawish, Sr.				Emily M	atilda	Crat	er	
3 . ar	permit Pages 1 and 2 should be Deparment of Health and Meria Important: If Item 27 is marked any injury or other traumatic avonce.	į i	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Addres	s (Street	and Number or Ru	ral Route Num	ber, City	or Town, State, Z	(ip Code)
No.	and 2 patth n 27		William K. Jawis								Marylar	
JAWISH FXP 4/10	2 = 5 D		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	20b	 Place of Dispo cemetery, crei 	osition (Na matory or	me of other plac	e) Anr	Date il 15,	20c.	Location - City or	Town, State
S.ZE	Page In the Page		4 Donation 5 Other (Specify)		ational	Crem	ator	у 1112	006	Fal	ls Churc	h, Virginia
3 0 =	mit por y in		21. Signature - Funeral Service Licen	99	The second secon				-0-07 TO 17 TO 17		r's Sons	
ZX.	89 = 9		John a grow	-	5.	130 W	isco	nsin Ave	. N.W.	Wash	ington,	D.C. 20016
124			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the de ne cause on each line.	eath. Do not en	ter the mo	de of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pn	evmoni	12						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons		44						
	Examiner	_	Sequentially list conditions,	0								
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate sauss. Liter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):							
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a cons	equence of):							
760,	be ey ician buria	calE										
387	leath certificate b attending physic of for use as the b			d							1	
Division of Vital Records, P.O. Box 68	certif iding	by Physician/Medi	IF FEMALE:	3c. If yes, outcome of pred	nancy						23d. Date of deli	VAD/
B	eath atter I for u	car	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o		∃Ectopic p ∃ Other (s					Month	Day Year
o.	that the de ed by the detached	İsk	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
σ.	that the	7	Part II. Other significant conditions co	ntributing to death but not r	resulting in the u	inderlying	cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
sp.	uires 1 sign 1d be	D	Myo Car Lich	in foretien	Renal	in	Le c	ien cy	1 🗆	Yes :	2 □ No 3 □ Pro	obably 4 🖫 nknown
5	law requires t as been signe 2 should be o	Completed		Arrhy thm	,			J	24a. Wa	s an	24b. Were au	tonsy findings available
Re	The lay	Ĕ	Dementia	Drawing	105				aute	opsy formed?	death?	topsy findings available completion of cause of
a	ician: Ti certificate rector, pa		25. Was case referred to medical	U				00 Disease Des	1 ☐ Yes		lo 1 ☐ Yes	2½ No
Ē	ding Phyaician: The In. After this certificate ha	To Be	evaminer?	lospital: 1 ☑Inpatient 2	☐ ER/Outpatier	nt 3 D	OA Oth	er: 4 Nursing H			6 □Other (Spec	26.1
ō	g Physical this seral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)			28c. Injun Worl		28d. Describe		<u>``</u>	ary)
on O	th: Afte	ē	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)) Injury	м		k? Yes 2 □ No				
Vis	Attendi r death. ector: A by the fu	=	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al	t home, farm, str	reet, facto	y, office		28f. Location	(Street a	and Number or Ru	ral Route Number,
á	s afte	Certification:	4 [] Homicide	building, etc. (Spe	спу)				City or To	own, Sta	ie)	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1X Certifying Phy	sician: To the best of my k	nowledge, deat	h occurred	at the tin	ne, date and place	, and due to the	e cause(s) and manner as	stated.
	tha Ho hin 24 tha Fu	Medical	one)	ner: On the basis of examination and manner stated.	mation and/or in	ivestigation	n, in my o	pinion, death occu	rred at the time	, date a	nd place, and due	to the cause(s)
	To the to to to to to to to to to to to to to	Σ	29b. Signature and title of certifier	,		29	c. Licensi D	3062167			ate signed (Monti	n, Day, Year)
	10		H. ARL	d. MD		-	00	062176		L	1110/06	
			30. Name and address of person who co	empleted cause of death (I	tem 23a) (Type,	Print)						
			Hossein Akhondi As					n Rd. Bet	hesda,	Mar	yland 20	814
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 8 2	32. Registrar's Sig	mature 6	melle	9					

Please Type or Print in Black Indelible Ink Everard R. Johnson State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 11, 2006 **Medical Examiner** Everard Ravelle Johnson 1653 hrs 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/B Rt. 301 @ Chew Rd Upper Marlboro Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Director Hours 220-82-8181 1 X M 2 F 35 05/27/1970 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Marvland Calvert Chesapeake Beach 1 Yes 2 X No or items 23a or 28a-f shor must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6555 13th Street 20732 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married White, etc. Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black ş or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r' injury or other traumatic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) Baltimore, MD 21215-0036 12 Manager Lumber Co. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Everard 0. Johnson å Betty Jane Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Latonia Jones-Johnson/wife 6555 13th St. Chesapeake Beach, MD20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Patuxent UMC Cem. 04/18/06 Huntingtown, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licens 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 22. Name and Address of Facility 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Month 2 Dav Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available s certificate has b rector, page 2 sh autopsy prior to completion of cause of performed? 1 ✓ Yes 2 No death? 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day Year) Apr 11, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto auto collision Natural 1645 hrs Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be or Town, State) N/B Rt. 301 Chew Road, Upper MArlboro, MD determined Homicide (Specify) Major Road / Highway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E April 12, 2006 30. Name an 35 ess of person who completed cause of death (Item 23a) ID Assistant Medical Examiner Pamela Southall, MD 111 Penn Street, Baltimore, MD 21201 State

32. Registrar's Signature

ORIGINAL

Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2250 DANIEL WEBSTER JONES, SR. 2004 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REGIONAL MEDICAL NICOMICA PENINSULA If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 T F 216-18-2611 85 January 1, 192**1** Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count wore. r 28a-f ehow 1 Yes 2X No Directo Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 21804 USA 308 Morris Mill Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other then "natural", or Iten filed within 72 hours after 1 Never Married 2 Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ۵ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Wicomico County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education self-employed bus contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 9 Nellie Bly Thomas 27 le markec traumatic e Grover N. Jones Pages 1 and 2 should Iment of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health acortant: If Item 27 le 308 Morris Mill Road - Salisbury, MD 21804 Geneieve Jones/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Calvary U.M.Cem. 04/17/2006 Fruitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Depart Import any Inj once. 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** NOM-/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibated events resulting in death) Last Due to (or as a consequence of). Examine To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physicien and attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? 1 Yes 2 1110 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient ဥ 3 DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: And in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MA who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 1

1 9 2006

32. Fegistrar's Signature

			for State Registrar	State of Maryland	l / Depa		Health and	Mental Hygi	-	13839
		#	Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
K	Physici /Medic		Ann	n Runkles Ke	pler			Apr. 6	, 2006 Year	10 A M
	Examir		4a. Facility Name (If not institution, give s				or Location of Dea	ith	4c. County of Death)
			9363 New I	Rd.		Macda			Talbot	
	Funeral Director			7. Age (In yrs. Ia.	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day Aug • 2	Yearl Cou	place (State or Foreign intry) rederick
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	f sho	ō	MD Talbo	ot	Mac	daniel				1 X Yes 2 ☐ No
	28a	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	untry?
	3a or	Funeral Director	9363 New Ro	i.		216	47			
	ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U.S	. 13. \	Was Decedent of I	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Amer	
9	or Ite		1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		_		no Hican, etc.)	Black, White	
සු	ours,	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 ☐xNo	Specify:		Specify: Whi	.te
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene dother than "naturel", or Items 23e or 28e-f show event, tre Medical Establish must be published at	Completed by	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occu kind of work done	during most of w	orking	6b. Kind of Business/li	ndustry
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2	Hygie Hygie ther int, in	ပိ	17. Father's Name (First, Middle, Last)		ues.	rgii eiig		ıme (First, Middle, M	apparel c	:0•
ano	d be	o Be	Oliver Wilson	Runkles				ne Hendr	·	
<u>Z</u>	mark mark	2	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	a Address (Street			City or Town, State, Zi	ip Code)
<u>∞</u>	alth ar 27 is r trau		Paul Kepler (Hu					laniel, l		,
ē,	s 1 a f Hea Itsm othe		20a. Method of Disposition	20b. Pla		sition (Name of natory or other pla		-	0c. Location - City or 1	own, State
Ë	Page lent o nt: If ry or		Marial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)					10/06	Middletow	m. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Empirement of Health and Mental Hygiene. Empirement of Health and Mental Hygiene. Empirement of the readmatic event, the Medical Examinational bencilified at ODGe.		21. Signature of Fundral Service License						neral Hom	
m	Depermine on his		() which	MOH		31 E. M	ain St.	. Middle	etown. MD	21769
	Physician		23a Part1. Enter the disease, or complications of the property	cations that caused the death. e cause on each line.	Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory arre	st,	Approximate Internal Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					l
왕.		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a conseque	mea of):					
ó	ate be executed hysicien and he burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	ate be hysici the bu	licai								
Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phiral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 2: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	leath 3□	Ectopic pregnance Other (specify)	у		23d. Date of deliving Month	very Day Year
o.	t the by the ache	hys	9 Unknown	9□ Unknown						
rds, P.	w requires that been signed should be der	by	Part II. Other significant conditions con	tributing to death but not result	ing in the ur	nderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Records,	The law requite has been age 2 should	Completed			<u> </u>			24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
<u>ta</u>	ian: rtifica stor. p	Bec	25. Was case referred to medical				26. Place of De	eath (Check only one		20110
	nysic nis ce direc	10 E	examiner? 1 Tes 2 No	ospital: 1 Inpatient 2 E	R/Outpatien	t 3 DOA	ner: 4 🗆 Nursing	Home 5 Resider	nce 6 Other (Spec	ify)
ion of	Attending Pt ir death. ector: After th by the funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Inju Wo	ry at	28d. Describe how		
Division	s after de s after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowner: On the basis of examination and manner stated.	ledge, death on and/or inv	n occurred at the to restigation, in my	me, date and plac opinion, death occ	e, and due to the car curred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
)	To t To t	W	29b. Signature and title of certifier	XMM/		290: bicen	se number	29	d. Date signed (<i>Month</i>	Dey, Year)
	10		30. Name and address of person who co	29466 Pinta	ail I	r. Eas	ston, M	D 21601		
	Sta Registr		31. Date filed (Month APR 2 4 2	32. A distrar's Signatu	B A	book				

			For State Registrar	State of Marylar	-	artment of F rtificate of			4000	13840
			negistrar Decedent's Name (First, Middle, Last)			imouto or	Douin	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia		Frederick	Haro	1.4	Kninn	enberg	Month April	Day 2006	7:15 P M
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	Examili	eı	809 Sunbury Avenu	е.		Cumb	erland		A1	legany
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	b 0.5	Birthplace (State or Foreign Country)
	Director		714-05-6914	M 2□F 94	Yrs.	Months Days	Hours Min.	(Month, Day 08/26/	7, Year) 1911 M.	aryland
	P .	Ì	Usual Residence of Decedent							
	show	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	Se-f	cto	MD Allegan	У		Cumberlan				1 ∑Yes 2 ☐ No
	or 2	Direct Part of the	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	s 23s	Funeral Director	809 Sunbury			2150			USA	
	er de Itam	nue	The state of the s	2. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, W	mencan Indian, hite, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 ⊠ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Itams 23a or 28e-f show he Medical Examinar must be notified at	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	
7	n "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	rking		ŕ
2	d with giene or tha	mo;	12	College (1-401 5+)	Ag	ent			Transpor	tation
힏	e file al Hy othe vant,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>a</u>	uld b Ments rrked	10	John	Knip	penberg	5	Rosin	a Ma	rgaret 1	Kiifner
an	and I sme		19a. Informant's Name/Relationship (Ty)	oe, Print)		•			r, City or Town, State	
	and and n 27		Cleo D. Knippenber		_	Sunbury	Avenue,			1502
ore	of Ho of Hi of itar		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R		Place of Dispo cemetery, crei	sition (Name of matory or other pla	се)	Date	20c. Location - City	or Town, State
Ē	Pag ment ant: jury c		* 4 ☐ Donation 5 ☐ Other (Specify)	Cui	mberlar	d_Cremat	ory 04/	14/2006	Cumberlan	d, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Furieral Service License	9	22	2. Name and Addre	ess of Facility A	dams Fam	ily Funera	al Home, P.A.
_	707 # 0	-	Laket C. C	Meny					rland, MD	21502
F			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.						Approximate Interval Between Onset and Death
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н	/Medical Examiner		Tooling in doding	Due to (or as a conse	quence of):					
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ω.	deat	sicia	in the past 12 months? 1 \(\sumset \text{Yes} 2 \sumset \text{No} \)	4☐Pregnant at time of		Other (specify)	,		Month	Day Year
P.O.	The law requires that the death centate has been signed by the attendin page 2 should be detached for use	by Physician/M	9 □ Unknown							
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ord	w requir been si should	ted						1 U Y	'es 21 No 3 □	Probably 4 Unknown
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<u>S</u>	death death ctor: / the	ica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome farm str			28f. Location (S	itreet and Number or	Rural Route Number.
≧	after Dira	erti	4 Homicide determined	building, etc. (Spec	fy)			City or Tow		,
	spite nours neral			ician: To the best of my kn						
	ne Ho 1 24 t ne Fu ietely	edicai	(Check only 2 Medical Examination)	ler: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	ppinion, death occ	urred at the time, o	date and place, and o	lue to the cause(s)
	To the Hospitel or Attanding Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	A .1		29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
)	(5)		Maken Tran	s (). 15	meral) D001	4865		April 1	4, 2006
			30. Name and address of person who co	. ,		Peirit)				
	NOB		Robustiano J. H			Memorial	Avenue,	Cumberl	and, MD	21502
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	•					
	Registr	αı	APR 1 4 2006	Care a Ch. Com	all I					

		For State Registrar	State of Marylar		artment of H			jiene	J6	3841
Physici /Medic		Decedent's Name (First, Middle, Last, Eri C		rim			2. Date of Dea	Day 12	Year Ob	3. Time of Death 1045 AM
Examir Funeral Director		4a. Facility Name (If not institution, give Clinton Nursing 15. Social Security Number 6. Sept. 19-98-5637	Rehabilita x, 7. Age (In yrs	tion(er last birthday) 7 Yrs.	4b. City, Town, of the City of	If Under 24 Hrs. Hours Min.	> .	Prir	Coun	ace (State or Foreign try)
aryland show	_	Usual Residence of Decedent 10a. State 10b. County MD Prince		ity, Town or Lo	cation					0d. Inside City Limits 1 XYes 2 No
with the Marylan a or 28a-f show by croffled at	Directo	10e. Street and Number 9211 Stewart Lane	deorges CI		101. Zip Code 20735	5		•	of What Coun	try?
itied within 72 hours after death with the Maryland Hygiene. Hygiene. Ither then "natural", or items 23a or 28a-f show out, the Medical Examiner must be rediffed at	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	'		lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14.	Race - America Black, White, e	an Indian, etc.
within 72 hour and.	Completed t	15. Decedent's Edu (Specify only highest grad	ication	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of word d)	rking	16b. Kind o	of Business/Ind rtment lding	
al ylailu Z should be filed v and Mental Hygie s marked other umatic event, th	To Be Co	17. Father's Name (First, Middle, Last) Mohomond Karim				Ruth K		Maiden Sun	name)	
s 1 and 2 f Health a flem 27 is other tra		19a. Informant's Name/Relationship (T) Ruth Karim (Mot) 20a. Method of Disposition	ner)	5233 Place of Dispo	Marlboro	and Number or Ru Pike #2	04 Capit	ol He	ights M on - City or To	ID 20743 wn, State
permit. Pages Department of Importent: If It any injury or o		1	IVIC	22	et Cemete	ess of Facility	22/06		ington,	
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D. DOX OC he death certifics the attending pt ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1□Live birth 2□Fel 4□Pregnant at time of 9□Unknown	al death 3	Ectopic pregnanc Other (specify)	у		23d.	Date of delive Month	ry Day Year
wrequires that the deben signed by the should be detached	þ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to			e cause of death?
The The	Completed						1 ☐ Yes	med? 2 No	4b. Were autop prior to con death? 1 \(\text{Yes} \)	osy findings available inpletion of cause of 2 No
JIN OI Jing Phy After this funeral d	ertification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Inju	her: 47 Nursing I	ath (Check only o Home 5 Resid 28d. Describe h	lence 6 🗆)
DIVISION To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (S City or Tox		umber or Rura.	I Route Number,
he Hosp in 24 hou he Funei pletely fil	edical	(Check only 2 Medicel Exem	vsicien: To the best of my kr iner: On the basis of examir and manner stated.	nowledge, death nation and/or in	vestigation, in my	opinion, death occi	urred at the time,	date and pla	ice, and due to	the cause(s)
To I To I	Σ	29b. Signature and title of certifier (me -		29c. Licen:				gned (Month, I	
		30. Name and address of person who c	completed cause of death (Ite	em 23a) (Type,	Print)	ringston	Rond.	Fort	WASH:	nstry un.
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 7 2	32. Pegistrar's Sign	nature	a de	·	,			

1 - For State Registrar

	Physici	an KAREN LEWIS 2. Date of Death Amonth / Day Year / 12.02 Am											
i de la companya de l	/Medic Examin		KAREN 4a. Facility Name (If not institution, give si	treet and number)	LEWIS	4b. C	ty, Town, or	Location of	of Death	ripiri		nty of Death	1
100	EXAMI	E	DOCTOR'S HOSPITA				ANHAN					CE GEO	
	Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birt	thday) If Uni	der 1 Year S Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day FEB 28			place (State or Foreign
	Director		215-90-7396	M 2127 4	1 `	Yrs.				FEB. 28	1965	5 MAR	intry) YLAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	f sho	ō	MD PRINCE GE	ODCETC		ENBELT							1. Yes 2 □ No
	the f	rect	10e. Street and Number	OKGE 5	GKEI		Zip Code			1	0a. Citizen	of What Cou	intry?
	3a of	ā	9104 SPRING HILL I	ANE # 10	3		0770				U.S		,
	ms 2	by Funeral Director		2. Was Decedent B		13. Was De	cedent of H	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Ameri	
9	or he	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	10		2X No		i, Puerto	Hican, etc.)		Black, White, ec <i>ify:</i>	
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23e or 28e-f show event, the Medical Expirative court by chalifiest at	d b	3 Widowed 4 Divorced	Year or Dates:	1								BLACK
<u>.</u>	c 2 34	lete	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's U (Give kind of life, DO NO)	sual Occup work done o	ation during most	t of worki	ng	16b. Kind of	f Business/Ir	idustry
72	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5		HOUSE		7			PRIV	ለጥፑ	
	Hygi other	Be C	17. Father's Name (First, Middle, Last)			поовь	WILL	18. Mothe	r's Name	(First, Middle, I			
Maryland		To B	WALTER E. LEWIS	Sr.				LA	URA	BAKER			
ar S	2 should and N ls mail		19a. Informant's Name/Relationship (Typ	e, Print)	19b.	Mailing Addre	ess (Street	and Numbe	r or Rura	l Route Number	, City or To	wn, State, Zi	p Code)
	5 ₹ Z ≡ Z		DARRELL J. LEWIS/H	USBAND					ANE	# 103 G	REENBE	LT,MA	RYLAND 20770
ore ore	A O		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	moval from State	20b. Place of cemeter	Disposition (f y, crematory o	lame of r other plac	e)	C	ate	20c. Locatio	on - City or T	own, State
Ē	Pages tment of I tant: If its jury or o		4 ☐ Donation 5 ☐ Other (Specify)	RIVERI	DALE CI							IARYLAND	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenser	. 00			and Addres		, ,	. B. JE			
	20244		23a. Part1. Enter the disease, or complic	eations that caused	the death. Do n					LANDOV.		KYLAND	20785 Approximate
Н			shock, or heart failure. List only one Immediate Cause (Final	cause on each lin	0.0			o, sport as	L	i rospiratory am	031,		Interval Between Onset and Death
Sp.	Physician /Medical		disease or condition resulting in death)	Due to lor as	a consequence of	10 cen	1	shoc		* 4	ρ		
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a				<i>-</i>		17			
	nd	Examiner	that initiated events C.		Melite	res	3112	m	1	21/1/c			
Ď	oe exe cian a rurial-		resulting in death) Last	Due to (or as a	a consequence d	of):		/		,			
Box 68/60	death certificate be executed a attending physician and d for use as the burial-transit	Iclan/Medical	d.					-+					
×	certifi iding	/Me	IF FEMALE:	sc. If yes, outcome	of pregnancy						224	Date of deliv	1004
ñ	death e atter id for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant at	2 Fetal death	3 ☐Ectopic 5 ☐ Other		,			1	Month	Day Year
o		Physi	9 Unknown	9 Unknown									
ກັ	ss tha	by P	Part II. Other significant conditions cont	ributing to death bu	ut not resulting in	the underlyin	g cause givi	en in Part I.		23e. Did tot	oacco use co	ontribute to t	the cause of death?
								s 2 No	3 Prof	bably 4 ⊠Unknown			
									24a. Was a autops	v	b. Were auto	opsy findings available ompletion of cause of	
<u> </u>	Th ate pag	Con								perform	ned? 2 No	death?	2 [™] No
VIII	certifical rector, p	Be	25. Was case referred to medical examiner?	ospital:			Oth			(Check only on			
0	Phys r this ral dii	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 L'inpatier			DOA Injun	at □ Nu		me 5 ☐ Reside			(y)
0	Attending Physicien: r death. ector: After this certific by the funeral director,	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	(Year) In	njury M	28c. Injun Worl	<br Yes 2 ☐ l			,,		
DIVISION	of or Attendi after death. Director: A d in by the fu	Iffica	3 Suicide 6 Could not be determined	28e. Place of Inju	iry · At home, far	rm, street, fact	ory, office					mber or Rur	al Route Number,
5	tel or rs afte el Dire ed in t	Certification:	4 Homeide	building, etc	(Specify)					City or Towr	i, State)		ŀ
	To the Hospitel of within 24 hours at To the Funerel D completely filled in		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	er. On the basis of	examination and	, death occurr	ed at the tin	ne, date and pinion, deat	d place, a	and due to the ca	ause(s) and	manner as s	stated.
	To the hwithin 24 To the F complete	Medical	29b. Signature and title of certifier	and mamper sta	ted.		29c. License						
	T with		255. Signature and other processings	1	1	1			'n	2		ned (Month,	
)	(30. Name and address of person who con	moleted cause of d	path (Item 23a) (Type Print\	D.	3135	/		H pri	1 15,	2000
_	9		Linda Washington M	D 8186	eath (Item 23a) (Road 1	anhan	Md	20706				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

13842

DHMH 17 Rev 1/2001

State

Registrar

APR 1 9 2006

31. Date filed (Month, Day, Year)

Registrar's Signature

			1 - For State Registrar	State of Maryla		rtment o			ınd Me		iene •g.No.00	6	138	43
	Physici	an	1. Decedent's Name (First, Middle, Last)						2	. Date of Deat		Year	3. Time of	Death
	/Medic			GARET LEISE	ENRING					pril	17 ^{Day} 200		9:30	Ам
7	Examin	er	4a. Facility Name (If not institution, give str	eet and number)		4b. City, To			f Death		4c. County			
			Record Street Home 5. Social Security Number 6. Sex	7. Age (In vr	s. last birthday)	Frede		K If Under 2	24 Hrs. 8	. Date of Birth	Fred			or Foreign
	Funeral Director			2015	34 Yrs.		Days	Hours	Min.	(Month, Day, une 24	Year)	0h:	hplace (State o untry) LO	or r Grengin
	Maryland e-f show	tor	10a. State 10b. County Maryland Frederick		city, Town or Loc ederick								10d. Inside Ci 1 X Yes	ity Limits 2 No
	h with the 23e or 28	al Director	10e. Street and Number 115 Record Street			10f. Zip Co	ode 1701			1	0g. Citizen of U . S	What Co	ountry?	
980	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show tha Madigal Exard nor mail to mailled at	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If	Vas Deceden Yes, specify ☐ Yes 25	Cuban	panic Orig , Mexican, Specify:	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)		ck, White	nican Indian, e, etc.	
Maryland 21215-0036	filed within 72 ho Hygiene, ther than "netur ont, I'm Wedisal	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give I	ent's Usual C kind of work of NOT use i lookkee	done du retired)	iring most	of working		16b. Kind of B		,	
land;	be de la la la la la la la la la la la la la	To Be C	17. Father's Name (First, Middle, Last) Frank Miller				1			First, Middle, M	Maiden Sumar Chy	ne)		
lary	s m		19a. Informant's Name/Relationship (Type	-							City or Town			
	an Bail n 2 rer	18	Mrs. Charlotte Robi				, Md. 2							
lore	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren		Place of Dispos cemetery, crem				Date		20c. Location			
Baltimore,			'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fure 1, Se area Ucepsee,	Sn	ithsbur			-		1,51			Maryla	nd
Ba	permit. Departr Importe any inju		South A	tally	/ 12	01 NOF	RTH	<u>MARKI</u>	ET ST	., FREI	ERAL HODERICK,	MES,	P.A. 21701 Approximate	
	Physician /Medical Examiner	Examiner	23a. Kart1. Enter the disease, or complies shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underving Cause (Disease or Injury that initiated events c.	Due to (or as a conse	iquence of):						a of les	and a	Interval Bett Onset and I	
. Box 68760,	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 7 No	Due to (or as a conse	nancy tal death 3	Ectopic pregr Other (specia					23d. Da Mc	te of deli		Yea r
, P.O.	that the ed by th detache		9 ☐ Unknown Part II. Other significant conditions contri	9∐Unknown buting to death but not re	sulting in the un	derlying caus	se given	n in Part I.		23e. Did tob	pacco use conf	ribute to	the cause of d	eath?
rds	en sign	ed by	Appertension							1 🗌 Ye	s 2 No	3 □ Pr	obably 4 🗆	Jnknown
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of	ding Phys n. After this funeral di	ation; To	27. Manner of Death 1 Accident	pital: 1 ☐ Inpatient 2[28a. Date of Injury (Month, Day Year)	28b. Time of Injury		. Injury a Work?	at	280	5 🗌 Reside d. Describe ho	ence 6 20th ow injury occur	_	Assist es	Hing
Division	itel or Attencts after death of Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, of	ffice		28f	Location (Sti City or Town	reet and Numb i, State)	er or Ru	ral Route Num	ber,
	To the Hospitel or I within 24 hours after To the Funeref Directonpletely filled in b	ledical	(Check only 2 Medicel Exemine one)	ien: To the best of my kr :: On the basis of examinand manner stated.	nowledge, death nation and/or inv	estigation, in	my opir	nion, death	d place, and h occurred	at the time, da	ate and place,	and due	to the cause(s)
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	1		30. Name and address of person who com	eleer me	2:30	erint)	911	317	Fre	Lere	t, mo	17	1701	
	Sta Registr		31. Date filed (Month, Pay Rear) 8 20	06 32. Resistrar's Sign	nature A	bull	,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 13, Physician 5:40 A M 2006 Carlos F. Lopez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 8412 Tea Rose Drive Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 49 Yrs. May 18, 579-94-3018 Bolivia Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 8412 Tea Rose Drive 20879 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1☑ Yes 2□ No Specify: Bolivian Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hote1 College (1-4or 5+) than Elementary/Secondary (0-12) Building Maintenance Boiler Engineer permit. Pages 1 and 2 should be filled v
Department of Health and Mental Hygies
Important: If Item 27 is marked other It
any injury or other traumatic event, Ite 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aurelio Lopez Demetria Camacho 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8412 Tea Rose Drive, Gaithersburg, MD Elizabeth A. Lopez / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 18, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Germantown, MD 4 □ Donation 5 □ Other (Specify) All Souls Cemetery 2006 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Amyotrophic Lateral Sclerosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physicien Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year be detached for 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No hes this certificate 2**X** No 1 Yes funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Tyes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Attending 1 🔀 Natural 5 Pending 1 Tyes 2 No death. 2 Accident completely filled in by the Director: 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie April 14, 2006 19267 DC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John J. Kelly, Jr., M.D. 2150 Pennsylvania Ave. N.W. #7-404 Washington, D.C. 31. Date filed (Month, Day, Year) APR 18 2006 State Registrar

State of Maryland / Department of Health and Mental Hygiene

				,			f Death		Reg. No.) 13043
Dissolution		1. Decedent's Name (First, Middle, Las						2. Date of Dea	Day	3. Time of Death
Physici /Medic		Bertha E. L					4b. City, Town, or L	APPLL -	12, 20 4c. County o	
Examin	ner	4a Facility Name (If not institution, give BLOOKE GROVE REHAM		11 01.0		ENTER		SPRING		STGOMERY
		5. Social Security Number 6. S		(In yrs. lest b	irthday) If	Under 1 Yea	r If Under 24 Hrs.	8. Date of Birth (Month, De)		Birthplace (State or Foreign Country)
Funeral Director		358-05-1313	□M 2XF	91	Yrs.	onths Day	s Hours Min.	July 2	1,1914	Country) MI
pue #		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Locati	on				10d. Inside City Limits
Mary Feet	ţ	FL Pasc	0	N	.P.R.					1 ☐ Yes 2 🛣 No
h the	je	10e. Street and Number				Of. Zip Code			10g. Citizen of WI	nat Country?
23e c	al	7540 Birdwood Co	urt				4653			ed States
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.	To Be Completed by Funeral Director	11, Marital Status 1 ☐ Never Married 2 ☐ Married 3 【X Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒N If Yes, Give Year or Dates:	ever in U,S.			Hispanic Origin? (S _i ban, Mexican, Puerto o <i>Sp</i> ec <i>ify:</i>	pecify Yes or No- p Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
in 72 hou	oleted	15. Decedent's Ed (Specify only highest gre	de completed)		a. Decedent (Give kind life. DO	's Usual Occ of of work don NOT use reti	upation le during most of work red)	king	16b. Kind of Bus	iness/Industry
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e filec Il Hyg other	Se C	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle,	Maiden Sumame)
Venta	2	Joseph Matheson					Laura			
bemit. Pages I and 2 should be file Department of Health and Mental Hy mportant: If item 27 is merked other sny injury or other traumatic event 2008.		19a. Informant's Name/Relationship (1			et and Number or Ru			
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permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Service Licen	See /		22. Na De	ame and Add er Par	ress of Facility De k Drive, (eVol Fun	eral Hom	ne, 10 East
		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused	the death. Do	not enter th	ne mode of d	ying, such as cardiac	or respiratory ar	rest,	Approximate
Physician		snock, or neart failure. List only	one cause on each in	ie.						Interval Between Onset and Death
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that the sed by dete	Y P							,,,	168 2 940	5 Probably 4 Onkilow
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Completed by Physiclan/							24a. Was perfo	an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
hysicien: The law his certificate has b il director, page 2 s	E							101	/es 20010	1 ☐ Yes 2 ☐ No
ien: rtifica ctor, p	Bec	25. Was case referred to medical					26. Place of Dea	th (Check only o	ne)	1000
nysici lis ce i direc	10	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		Outpatient	3LI DOM			dence 6 □Othe	
~ = ~	ation:	27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b	. Time of Injury	28c. In W M 1	juryat /ork? □Yes 2□No	28d. Describe I	now injury occurre)d
or Atters of the control of the cont	ertific	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home, :. (Specify)	farm, street,	factory, offic	е	28f. Location (S City or Tox		er or Rural Route Number,
To the Hospital or Attending Physicien: The Is within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Certification:		ysician: To the best on hiner: On the basis of and manner sta							
To the To the Comp	Me	29b. Signature and title of certifier	-			29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
		MMATTE	UDING PH	YSICIA	~	1)	12046	4	APRIL 1	2,2006
6		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who CACE DLODKE Human and address of person who CACE DLODKE Human and APR 18 2	completed cause of do	eath (Item 23a	(Type, Prir	E SCH	SOLROAD S	ANDY S	PRING M	ARYLAND 2086
Sta Registr		31. Date filed (Month, Day, Year)	32. degistra	ar's Signature	An	W)				

			1 - For Stete Registrar		State of Ma	aryland		tificate of		F	Reg. No.	000	13846
	Physicia	an	1. Decedent's Name (First, Min	ddl e , La						2. Date of Dea Month APRIL	ith 1 ^{Day}	, 2006°	3. Time of Death 02:45 a.M
	/Medic Examin		Georgia 4a. Facility Name (If not institu	tion, giv	De 11 e street and number)			Liller 4b. City, Town, o	r Location of Dea			County of Death	02.45 a
	LAMINI	Ç.	Memorial	Hos	oital			CUMBERI	LAND		A.	LLEGANY	
	Funeral Director		5. Social Security Number 217-10-6162	6. 5	DM OFF	9 (In yrs. Ias	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, Year)		place (State or Foreign ntry) 1.sylvania
	land		Usual Residence of Decedent 10a. State 10b. Cour	nty		10c. City,	Town or Lo	cation				1	10d. Inside City Limits
	Mary	tor	MD A1	lleg	anv			Cumberla	and				1 ☐ Yes 2 🖾 No
	th the	Director	10e. Street and Number		•			10f. Zip Code	*114		10g. Citi	izen of What Cou	ntry?
	23a	rain	13209 Val	1ey	Road, NE				21502			USA	
0	is 1 and 2 should be filed within 72 hours after death with the Maryland of theath and Mental Hygiene. If heath and Mental Hygiene, and the strength of the strength of the strength of the strength of the show other traumatic event, the Madical Examinar must be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divorce		12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of H fYes, specify Cuba I□Yes 2∑No	lispanic Origin? (S an, Mexican, Puel Specify:	Specify Yes or No- rto Rican, etc.)		14. Race - Ameri Black, White, Specify: W	
3	2 hou		15. Deced	lent's E	ducation		16a. Deced	lent's Usual Occup	ation		16b. Ki	ind of Business/In	dustry
2	thin 72 9. Medi	Completed	(Specify only hig Elementary/Secondary (0-12		ade completed) College (1-4or 5	+)	(Give life. L	kind of work done of OO NOT use retired	during most of wo d)	orking			
7	ygjen ygjen t, th	Con	8				Mac	hine Ope	-			<u>[extile</u>	
2	be fill be fill be defined by out of the bear of the b	Be	17. Father's Name (First, Midd	le, Last			C			me (First, Middle,			
Ž	hould d Mer mark matic	ဥ	George 19a. Informant's Name/Relation	nshin /	Watson Type Print)		Coop		Etta and Number or 8	r I ural Route Numbe	orer		ertz
<u>2</u>	Ith an Ith an trau		Dennis Bonne		friend					E., Cumbe			21502
ວ ກັ	permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trat once.		20a. Method of Disposition 1 🔀 Burial 2 □ Crematic			20b. Plac	ce of Dispo	sition (Name of natory or other place	ca)	Date	20c. Lo	ocation - City or To	own, State
	t. Pa rtmen rtant: njury		4 □ Donation 5 □ Other 21. Signature of Fune ral Servi			Suns	set M	emorial F	ark 04/	19/2006	Cur	mberland	, MD
0	Depariment of the parameter of the param		21. Signature of Furnital Servi	-0	Culu					dams Fami t, Cumber	-		Home, P.A. 1502
			23a. Part1. Enter the disease shock, or heart failure. L	or com	plications that caused one cause on each lin	the death.	Do not ent	er the mode of dyin	ig, such as cardia	c or respiratory ari	rest,		Approximate Interval Between
I	Physician		Immediate Cause (Final disease or condition resulting in death)	100	. Sepsi	S							Onset and Death Weeks
	/Medical Examiner		resulting in death)	1	Due to (or as	a conseque	nce of):						
		e.	Sequentially list conditions,		b. ESCh (Due to (or as:	2 Consaquel	hia near of):	Coli					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1									
Ś	ficate be executed physicien and s the burial-transit	Exa	resulting in death) Last		Due to (or as	a conseque	nce of):						
,00/00	physic the bi	edicai		•	d								
		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome	2 Fetal de	eath 3	Ectopic pregnancy	,		:	23d. Date of deliv	ery Day Year
į	the de	ysic	1 ☐ Yes 2 █ No 9 ☐ Unknown		4□Pregnant at 9□ Unknown	time of deal	tn 5∟	Other (specify)					
ָר (צְיִּ	The law requires that the death certit ste hes been signed by the ettending page 2 should be detached for use as	ρ	Part II. Dther significent cond	litions (contributing to death bu	ut not resulti	ng in the ur	nderlying cause giv	en in Part I.		bacco u		he cause of death?
222	e iaw rec hes bee le 2 shot	Completed								24a. Was a autops	sy	24b. Were auto prior to co death?	opsy findings available impletion of cause of
<u> </u>	n: Th ficete									1□ Yes	2 √ No	1 ☐ Yes	2 No
=	s certification	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	icai	Hospital:	nt 2□EE	VOutpatien	t 3 DOA Oth	or	ath (Check only or Home 5 ☐ Resid		S DOther (Special	6.1
	ding Phy th. : After this funeral d	-	27. Manner of Death 1 Natural 5 ☐ Per	ding stigatio	28a. Date of Injur (Month, Day	y 2	8b. Time of Injury	28c. Injun Wor		28d. Describe h			y)
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: Atten this certificate hes completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Cou	ild not b imined	e 28e. Place of Inju- building, etc		e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet an n, State	d Number or Rura)	al Route Number,
	Hospita 24 hours Funere etely fille	edicai C	29a. Certifier 1 Certification (Check only one)	ying Pl	nysicien: To the best on niner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tin restigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time, d	ause(s) late and	and manner as s I place, and due t	stated. o the cause(s)
	within Compl	Me	29b. Signature and title of cert	ifier	1		^	29c. Licens	e number	2	29d. Dat	e signed (Month,	Day, Year)
	9.		Melant	ian	0 9:16	when.	Ch	up D	-149	(c) A	pri	1 17 7,	2006
en	DO		30. Name and address of pers			eath (Item 2	За) (Туре,	Print)		,		1 1.2	4 ==
/	<i>7</i> ∧≫		Dr R Barrer 31. Date filed (Month, Day, Ye		Aemorial F			edical B	ldg, Cu	mber le	ano	MD	21502
	Sta Registr		31. Date filed (Month, Day, Ye	7 2	006	ar a digitatul	15	hack .	U				

Maryland Washington Rohrersville 10			ļ.		te of Maryland / Dep	artment of Health and I rtificate of Death	-	2006 13847
Mary Inc. Cally, Town or Logistics Topic Cally Town or Logistics Town or Log		/Medic	al	HELEN R. 4a. Facility Name (If not institution, give street as Washington Count	y Hospital	Hagerstown	April	17 2006 2:30 M
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The part of the pa		28e-f ehow	ector	10a.State 10b.County Maryland Washingto		rsville	100.	10d. Inside City Limits 1 ☐ Yes 2 🔀 No Citizen of What Country?
The part of the pa	0	or Items 23a or	Funeral Dir	20636 Bent Willo 11. Marital Status 12. Waa	s Decedent Ever in U.S. 13.	21779 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		U.S.A. 14. Race - American Indian, Black, White, etc.
The part of the pa	500-CIZI	ne. han "natural", c	mpleted by	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Coll	16a. Decs 16a. Decs Giv 1/6.	edent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	king 16b.	Kind of Business/Industry
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Physician (Medical Examiner) Physic		t of Health and fill tem 27 is n		Walter E. Little S	On 2063	6 Bent Willow Road osition (Name of ematory or other place)	d, Rohrersv	ille, Md. 21779 Location - City or Town, State
Physician Medical Examinor Examinor		Departmen Important: eny injury once.	6 A	21. Signature of Funeral Service Licensee R. hoel Brad	A ²	2. Name and Address of Facility ndrew K. Coffman I O East Antietam St	uneral Homore	ne, Inc. erstown, Md. 21740
resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		/Medical		Immediate Cause (Final disease or condition	Pneumo: ue to (or as a consequence of):	719	c or respiratory arrest,	Interval Between Onset and Death
Second S	100,	ysician and		c squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ATHYOSCL	erosis		years
Askerson Services of Services	S	the death certifically the attending phoched for use as the	ysician/Med	23b. Was decedent pregnant in the past 12 months?	Live birth 2 Fetal death 3 Pregnant at time of death 5			
26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 3 DoA 3 DoA 4 Date of Death (Check only one) 28. Date of Death (Check only one) 28. Date of Injury 3 DoA 4 Date of Death (Check only one) 28. Date of Injury 3 DoA 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Death (Check only one) 28. Date of Injury 3 DoA 4 Date of Death (Check only one) 28. Date of Injury 3 DoA 4 Date of Death (Check only one) 28. Date of Injury 3 DoA 4 Date of Death (Check only one) 28. Date of Injury 3 DoA 4 Date of Death (Check only one) 28. Date of Injury 3 DoA 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4 Date of Death (Check only one) 28. Date of Injury 4	L , L	ures triet signed by Id be deta	d by Pr	Part II. Other significant conditions contribution Alzheurer	g to death but not resulting in the	undertying cause given in Part I.		
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27. Manner of Death September Septembe	<u> </u>	ertific actor,	Be	evaminer?			ath (Check only one)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phans Rd Boonsboro MD 217/3	_	O 00	tion: To	27. Manner of Death Natural 5 Pending	Date of Injury 28b. Time	of 28c. Injury at Work?		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phans Rd Boonsboro MD 217/3	DIVISI	tel or Atten s after deat el Director: ed in by the	Certifica	3 Suicide 6 Could not be 28e.	Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phans Rd Boonsboro MD 217/3		ne Hosp in 24 hou he Funer pletely fill	edical	(Check only 2 Medical Examiner: Or	n the basis of examination and/or i	ath occurred at the time, date and place nvestigation, in my opinion, death occu	urred at the time, date	and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phans Rd Boonsboro MD 21713 State 31. Date filed (Month, Day, Year) 38. Registrar's Signature		A D	Σ	29b. Signature and title of certifier	12	29c. License number D 44996	29d.	Date signed (Month, Day, Year)
A STATE OF THE PARTY OF THE PAR		if		30. Name and address of person who complete Malik	d cause of death (Item 23a) (Type 2031)	Plappans Rd	Bonsbor	O MD21713

			For State Registrar	State of Marylan		artment of F			jiene 93. No: 0 0 6	13848
	Physicia	an	1. Decedent's Name (First, Middle, Last) STEPHE	LE	Tritta 1	2-		2. Date of Dea	th Day Year	3 M
	/Medic Examin Funeral	er	4a. Facility Name (If not institution, give str THE JOHNS HOFK 5. Social Security Number 6. Sex	7. Age (In yrs.		Qc.11.	r Location of Death No RE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	4c. County of De Baltim 9.8	ore irthplace (State or Foreign Country)
	Director	2	19_52_2283 Usual Residence of Decedent	55				August	23 1950	Maryland
	Marylan a-fehow	ctor	10a. State 10b. County , aryland Washing		y, Town or Lo	gerstown				10d. Inside City Limits 1 Yes 2 □ No
	with the	Director	10e. Street and Number			10f. Zip Code	4540	1	log. Citizen of What	
36	be filed within 72 hours after death with the Maryland Hygiene. At Hygiene. Ad other then "natural; or Items 23s or 28s-f show event, I'le Medical Exaction must be notified at	by Funeral	1401 Potomac Aven 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			1742 Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian,
15-0036	in 72 hou "natura eulical E	Completed	15. Decedent's Educa (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of world)	king	16b. Kind of Busines	ss/Industry
2121	er there,	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		Optician			Optical	Sales
_	0 = 0 >	To Be (17. Father's Name (First, Middle, Last) Harold William Lei	nhart					<i>Maiden Sumame)</i> n Art z Len	hart.
ary	2 shoul and M Is marl aumatl	F	19a. Informant's Name/Relationship (Type	e, Print)	1		and Number or Ru	ral Route Numbe	r, City or Town, State	, Zip Code)
e, N	1 end Health em 27		Constance M. Lenha 20a, Method of Disposition			Potomac sition (Name of matory or other plan			wn Marylan 20c. Location - City	
Baltimore,	permit. Pages 1 end 2 should b Department of Health and Ments Important: If item 27 is marked eny injury or other traumatic s page.		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	Sm	nithsbu	ırg Crema	tory 4-21			rg Maryland
Ba	Departiment Departiment Important Information Series Information Serie		21. Six alters of Funeral Service Licensee	Line						neral Home ryland 21742
	Physician /Medical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations hat caused the death cause on each line. SUDDEM Due to (or as a conseq	CARD	INC DE	- ATH		rest,	Approximate Interval Between Onset and Death MINUTES
	The law requires that the death certificate be executed to the law requires that the law requires that has been signed by the attending physicien and agget should be detached for use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseq	uence of).	F PANC	- REOT 1 T	-, £		5 MONTHS
.O. Box 6	at the death certific by the attending p tached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o Month	delivery Day Year
ds, P.	ires that I signed by d be deta	<u>م</u>	Part II. Other significant conditions cont		ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to		to the cause of death? Probably 4 _Unknown
Records,	ding Physician: The law require. h. After this certificate has been si funeral director, page 2 should t	Completed	MULTI DIZVG RE	SISTANT PSE	roporis	one ince	ection)			
/ita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	ospital:		. 04		th (Check only o	ne)	
6	Physi r this o	5. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie	IL SEL DON			lence 6 Other (S	pecify)
Division of Vital	or Atten fler deat Shector: in by the	Certification:	Matural 5 ☐ Pending 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifical Control of the Contro	Injury ome, farm, st (y)	M 1	rk?]Yes 2 □No	28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	ledical C		cien: To the best of my known. or: On the basis of examina and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	PF	MD	29c. Licen:	se number 056 88 4		29d. Date signed (Mo	
5	4-12		30. Name and address of person who cor		n 23a) (Type 600 A	Print)	St. BLAL	ock 658	BALTIMORE	MD 21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	1				

06-02704 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Laverne Marbley 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0142 hrs **Medical Examiner** Margaret Laverne April 21, 2006 Marbley 4a Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country) Wash DC Min Months Days Hours Nov 26, 1927 Director 212-22-0879 78 1 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 'n 10c. City, Town or Location 1 X Yes 2 No 28a-f show Prince George's Lanham Maryland death with the Maryland Director 10g. Citizen of What Country 10e, Street and Number 10f, Zip Code 20706 USA 6000 85th Street 23я Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Never Married 2 Married Yes 9 Black 3 XWidowed after 1 Yes 2 X No specify: 4 Divorced If Yes. Give Year Specify ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hot
Department of Health and Mental Hygiene,
Important: If item 27 is marked other than "mat
injury or other traumatic event. the Medical Exa Elementary/Secondary (0-12) College (1-4 or 5+) Microfiche Technician 12th Government 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leonard Price Margaret Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 1710 Allendale Place, Landover MD 20785 Sharon Marbley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 May 11,2006 Arlington, VA Arlington National Donation 5 Other Specify 21. Signature of Funeral Service Licers 22. Name and Address of Facility Latimore Funeral Services, P.A. 6906 Kent Town Drive, Landover MD 20785 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Sepsis secondary to pneumonia Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate couse Enter Underlyin, Caus-(Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X AMENDED item#1,23a,PII,27,perME,g856,6/14/06 TT XUNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease; Completed 24a. Was an 24b. Were autopsy findings available Diabetes mellitus autopsy prior to completion of cause of death? performed' 1 🗸 Yes ✓ Yes 2 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 V Yes 28a. Date of Injury (Month, Day, Year) After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the Lo and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD O.C.M.E. April 22, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner

31. Date filed (Month, Day, Year)

ORIGINAL

State Registrar

		•	For State Ragistrar		State of M	laryland	d / Depa <i>Cer</i>	ertment of I tificate of	lealth Deatl	and Mer		iene g. No.	006	138	50
()	Physici		1. Decedent's Name	(First, Middle, Last DAVID	THOMAS	MURPH	ΗY				Date of Deat Month April	h Day 15	Year 2006	3. Time of 0	Death A ^M
	/Medic Examin	_	4a. Facility Name (If	not institution, give	street and number,)		4b. City, Town,	or Location			4c. (County of Death		
	Funeral Director		Frederic 5. Social Security Nu 183-44-96	mber 6. Se	Al Hospita X 7. Ac X 2 F	a <u>1</u> ge (In yrs. Ia 50		Freder If Under 1 Year Months Days	If Unde	er 24 Hrs. 8. Min. Ma	Date of Birth (Month, Day, rch 18	1	Frederic 9. Birthp Count 956 Penn	lace (State or	
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	or 28a	Directo	10e. Street and Num					10f. Zip Code			10	0g. Citiz	en of What Cour	itry?	
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or itame 23a or 28a-f ehow any injury or other traumatic event, the Medical Examination to indiffied at ance.	by Funerai	11. Marital Status 1 Never Marrie 3 Widowed		12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	1	Was Decedent of f Yes, specify Cub	an, Mexic	an, Puerto Rica	Yes or No- an, etc.)		4. Race - Americ Black, White, Specify: W		
Maryland 21215-0036	within 72 hc ene. then "natur he Mudical.	Completed	(Special Special Special (Special Special 5. Decedent's Edi fy only highest grad idary (0-12)	ucation de completed) College (1-4or	5+)	(Give life. L	tent's Usual Occu kind of work done DO NOT use retire Lesman	i durina ma	ost of working			siness B		ge	
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ylar	Menta Menta arked artic ev	To Be	William 1	Hostetter	Murphy				Ir	ene Max	well				
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altimore,	Pages nent of ant: if i			☐Cremation 3 ☐ 5 ☐ Other <i>(Specify</i>	Removal from State)	,	derick	Cremato	ry	April 20			erick, M		
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			23a. Part1. Enter th shock, or hear	e disease, or comp t failure. List only o	lications that cause one cause on each	d the death	. Do not ent	er the mode of dy	ing, such a	as cardiac or re	spiratory arre	est,		Approximate Interval Betw Onset and D	veen
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	ertificating physe as th	Medi	tF FEMALE:										1.1		
P.O. Box	that the death certifed by the attending detached for use a	Physician/M	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	23c. tf yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	;y			2	3d. Date of delive Month	-	'ear
	law requires that the as been signed by th 2 should be detache	b	Part tt. Other signifi		ontributing to death		ılting in the u	nderlying cause g	iven in Par	t I.			se contribute to the		
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ō	g Phy ter this nerel d	n; To	27. Manner of Death	1	28a. Date of Inj	jury	28b. Time of				. Describe ho			<u>Y)</u>	
Division	To the Hospital or Attending Physical thin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	28e. Place of Ir		me, farm, str]Yes 2[Location (St. City or Town		d Number or Rura	i Route Numb	ber.
L	e Hospitai 24 hours a e Funerai C	edical Ce	29a. Certifier (Check only one)	Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examinat	wledge, death ion and/or in	n occurred at the vestigation, in my	opinion, d	and place, and eath occurred a	due to the ca at the time, da	ause(s) ate and	and manner as s place, and due to	tated. o the cause(s)	
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(25. A)(26.)	Sta Regist	ate rar	31. Date filed (Mont		9 2006	tras Signat		book	,						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 13.19b per fth 9856 6-9-06 vt.

State of Maryland 7 Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) April 15, 2006 **Physician** Irene E. McKenzie 06:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 205 McCulloh Street Frostburg Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 19-Sep-1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 200F Months Hours Min. 216-18-1956 86 Yrs. Maryland Director Usual Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other treumetic event, the Medical Examinat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 □ No Maryland Frostburg Allegany Directo 10e. Street and Number 205 McCulloh Street 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21532-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 ¥es 2 No Specify: δ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harvey Caton Sarah Brown 19b. Mailing Adwyndreet and Number or Ruranger Deer, City or Town, State, Zip Code)
941 Jones Wind 19a. Informant's Nama/Relationship (Type, Print) Bonnie Radditz daughter Wake Forrest N. Carolina 27587 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Frostburg Memorial Park 19-Apr-2006 Frostburg Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 lun 0 Approximate Interval Between Onset and Death a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MOS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) n signad by the a ld be detached fo 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has all director, page 2 autopsy rmed? 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 T Homicide 29a. Certifier 1🕇 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mas 500 MEMORIAL Cumbercan R 1 8 2006 egistrar's Signature 31. Date filed (Month, State Registrar

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	Funeral Director		5/7-34-6419	ex 7	. Age (In yrs 78	. last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth 13 Year	927		lace (State or Foreign Mington DC
	e Maryland a-f ahow	ctor	Usual Residence of Decedent 10a. State Maryland Calvert		10c. C	ity, Town or Lo		đ						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 6501 Quiet Court		·			0685				_	ited		•
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or teme 23a or 28a-f ahow event, the Madical Examitive must be must lied at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	es? ₩ No		Was Dece If Yes, spe	cify Cubai	spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	0-	Blac	- Americ k, White, white	
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land 2	should be filed within and Mental Hygiene. s marked other than umatic event, the Manalic event, the Manalic event.	To Be Co	12th 17. Father's Name (First, Middle, Last) Charles Jenkins E			homen	aker				(First, Middle Delores	, Maider			
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (William R. Muller		ınd						nard M			State, Zip	Code)
Baitimore,	Pages 1 a mant of He ant: if itam ury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specifi		ate Ma:	Place of Dispo cemetery, crea ryland	natory or o	me of other place rans	Apri Ceme	l 14 tery	2006 c				wn, Siate Iaryland
Balt	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licen)						ch Fune Port F				land 20676
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on or	ding Phy h. After this funeral d	ıtlon; To	27. Manner of Death Natural 5 Pending 2 Accident investigation			28b. Time of Injury		28c. Injury Work	4 🗀 (40)	2	ne 5 Resident				')
DIVISION	To the Hospital or Attending F within 24 hours aftar death. To the Funeral Director: After completaly filled in by the funer.	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At h , etc. (Speci	ome, farm, str	eet, factory	, office		2	28f. Location (3 City or Tou			r or Rural	Route Number,
	To the Hospital of within 24 hours af To the Funeral D completaly filled in	edicai	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be liner: On the basi and manne	s oi examina	owledge, death ation and/or inv	occurred estigation	at the time , in my opi	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s)	and man d place, a	ner as stand due to	ated. the cause(s)
	With To 1	Σ	29b. Signature and title of certifier N. Herd	000				DO C	number 2600	338		29d. Da	te signed	(Month, £	Day, Year)
	3		30. Name and address of person who o	completed cause	of death (Iter	n 23a) (Type,	Print) /	UAYA UOS	NTAI	ea 12	MEN	AR.			EDERICL
	Sta Registr		31. Date filed (Month, Day, Year) APR 1	7 2005	istra s Signa	ature	Some	ARI D					7	15	20678

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** P^{M} April 15 2006 3:25 James J. McElwain /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8490 Reservoir Road Fulton Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days 1**X**M 2□F Yrs 68 Sept 1, New York Director 080 30 3280 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other freumatic event, the Medical Exaction art must be codified at once. 10a. State 10b. County 1 ☐ Yes 2 No Director MD Fulton Howard 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 8490 Reservoir Road 20759 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1957-59 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James McElwain Mary Jane Duffy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) R.Hope McElwain/Wife 8490 Reservoir Rd Fulton, MD 20759 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gard. 4-20-2006 * 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** colon cance resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transil that initiated events resulting in death) Last and Due to (or as a consequence of) of Vital Records, P.O. Box 68760. attending physicien Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death Day Year ō Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 Probably 4 ₽Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? has page 2 20 No certificate 1 ☐ Yes Physician: ector. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1X Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DC 19653 6 April 17, 2006 4)00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John L. Marshall, MD 3800 Reservoir Rd NW Washington, DC 20007-2113 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2006 Registrar

			State of Maryland / Dep	partment of Health and Menta	_	13851
	0.40		Registrar .	ertificate of Death	Reg. No.	10004
	Physicia	an	1. Decedent's Name (First, Middle, Last) Stewart Grattan MAYSE	Mor		3. Time of Death
	/Medic Examin	4	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	
**	LXdiiiii		Washington County Hospital	Hagerstown	Washir	igton
32 J	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 229-20-8724 1 △ M 2 □ F 79 Yrs.		of Birth 9. Bi	nthplace (State or Foreign ountry)
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	inyland ihow		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	he Ma	Director		Hagerstown	10-000	1 Yes 2X No
	with t	Dir	10e. Street and Number 14014 Marsh Pike	10f. Zip Code 21742	10g. Citizen of What C	ountry ?
	death	Funeral		. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e		
36	s after or Ita	by Fu	1 ☐ Never Married 2 ☐ Married 1 ② Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	Specify:	white
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2	led wi lygien her th		12 4 cent	tral intelligence 18. Mother's Name (First,		nment
Maryland 21215-0036	d be f ental h ked of	To Be	George Grattan Mayse	Frances Ste		
ary	shou and M s mar	_	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or Rural Route		Zip Code)
	and 2 ealth a m 27 i			Jennings Way, Mickleto	total part 1	
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic event. The Medical Examiner mast be multified at once.		1 E Burial 2 Cremation 3 Exhemoval from State Local and	position (Name of permatory or other place) Cemetery 4/1/06	20c. Location - City o	
Ë	artmer ortant injury		, 200, 100, 100, 100, 100, 100, 100, 100		Millboro,	
Ba	Depa Impo any is		Fred L. Vestal	415 E. Wilson Blvd., F		_
3.			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			(de
Е	Examiner		Due to (or as a consequence of):	ania		اطم
÷	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by the initiation provided in the conditions of			
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
760,	icate be executed physician and s the burial-transit	calE	d			
89	rtificati ng phy as the		IF FEMALE:	****		
Вох	The law requires that the death certifica ste has been signed by the attending phi bage 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy	23d. Date of de Month	elivery Day Year
P.O.	the de y the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)		
	res that igned b be deta	by PI	Part II. Dther significant conditions contributing to death but not resulting in the		a. Did tobacco use contribute	to the cause of death?
ord	w require been sig should b	ted t	Acut Rend Failur Multi	organ fairlen	1 Yes 2 No 3 F	robably 4 Hinknown
Vital Records,	The law resete has be page 2 sh	Completed	cerebro Varanta Accentent	248		utopsy findings available completion of cause of
a			Distriction mallitas 25. Was case referred to medical		Yes 2 1 No 1 Ye	s 2□No
	Physician: r this certific ral director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Home 5		ecify)
n of	tending Physician: leath. tor: After this certific the tuneral director,	on: T	27. Manner of Death 1 Chatural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at 28d. De	scribe how injury occurred	
Division	Attending ir death. ector: Atter by the fune	icati	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	ation (Street and Number or F	Bural Bouta Number
Ď	i. 5 te o	Certification:	4 Homicide determined building, etc. (Specify)	City	or Town, State)	iara ribbio rambor,
	To the Hospital or Ati within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only 2 Madical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	to the cause(s) and manner as time, date and place, and di	as stated.
	thin 2, the P	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	1
)	F ≯ F 8	4) -out mo	D (2016	MARCH 2	
				LL ST HAGERSTE	en, mo	といいい
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 2 2006 32. egistrar's Signature	(See See		
			The state of the s			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 16, 2006 Grace Rebecca Nichols April 6:25P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Catherine's Nursing Center Emmitsburg Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr • 22, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Yrs. MD 218-18-7311 1909 Director Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumetic event, the Medical Examinar must be notified at 1 Tyes 2 No MD Frederick Middletown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Linden Blvd. 21769 USA death v 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Specify: White 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. It and Mental Hygiene. 7 Is marked other than "no College (1-4or 5+) Elementary/Secondary (0-12) dressmaker 6 garment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Kessler Specht Bessie L. Brengle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 2019) 7 () 2 permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n any injury or other treun 2002. Charles R. Nichols Jr. (Grandson) 11540 Gambrill Park Rd., Frederick, MD 20b. Place of Disposition (Name of cometery, crematory or other place Lake View Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 4/20/06 Sykesville, MD Donald B. Thompson Funeral Home 31 E. Main St. Middle 21 Sign three of Funers Service Lines 10 E. Main St., Middletown, MD 21769 Approximate Interval Between Onset and Death 23a. Part1. Enjoy the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Inmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that the death certificate be executed the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 2 □ No 9□ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performeda 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P after death. | Director: After to in by the funera After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel or within 24 hours aft To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of cert 22 The completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Freder SAJJAD A
31. Date filed (Month, Day, Year) MP. 32. Re State APR 1 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [1 - State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:14 AM 04 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Adventest Homes unto Takoma ameni 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, May 12 Birthplace (State or Foreign Country) 6. Sex **Funeral** , 1952 Virginia Min. 1 ☐ M 2 🔯 F Months Hours 53 225-76-9338 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10c. City, Town or Location r then "naturel", or iteme 23e or 28e-f ehow the Mudical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2008 Ft Davis St. SE # 201 20020 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Private injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be I Depertment of Heelth and Mental I Importent: If item 27 is marked o Harold Rayford Parker Mary Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7210 East Inwood St, Landover, MD 20785 Angela McDowney / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill 20a. Method of Disposition April 12 2006 Suitland, Md 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SVC, Inc 1425 D.L. McLaughlin's Funeral any in Svc. Maryland Ave, NE. Washington DC 20 A proximate 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner ed by the attending physiclen and deteched for use as the buriat-transit or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☒ No Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No leunor 1 ☐ Yes 260 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 (Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 MNatural 2 □ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) K. ASHAL MD 0006033 05 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Good Luch 302 ASHA 8100 31. Date liled (Month, Day, Year) 2. Registrar's Signature State APR 1 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 2006 Victor H. Parker Apri1 9:15p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sunrise of Annapolis Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min, (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1₩ 2□ F Director Yrs 17, 426-07-2102 88 Jan. 1918 Mississippi Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "naturel", or itema 23a or 28a-1 show injury or other treumstic event, the Madical Examinar must be notified at 10d. Inside City Limits 1 TYes 2X No Directo Annapolis Maryland Anne_Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ₩WII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Principle/Administrator Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should nent of Health and Men ဥ Samuel R. Parker Onnie Mae McPherson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health if Alan Parker/ Son 222 Lookout Lane, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home P. A. ode 1621 Opossumtown Pike, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dvance ROVS /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ettending physicien Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cther (specify) the detached 9□ Unknown 9 Unknown signed by t i be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1☐ Yes 1 Yes or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) ssis teo examiner? Hospital: 1 Inpatient 2 **N**0 Other: 4 Nursing Home Certification: To 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Dether (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funerei Dire the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50 124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Hwy d MAI 32. Regist 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month ALLIOPE PILAFIC ,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL KOCKVILLE 10NTGOMER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 577-54-1392 1□M 2€ F Director Chios, Greece 96 15,1909 Aug Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehow the Maulical Examiner must be notified at 1 Yes 2 □ No Potomac MD Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20854 10510 White Clover Terr. filed within 72 hours after death ! Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker other 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be life
Department of Heelth and Mental Hy
importent: If Item 27 is marked oth
eny hiury og other treumatic event 18 Mother's Name (First Middle Maiden Sumame) Be Helen Kavoukas George Kavoukas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10510 White Clover Ter., Potomac, MD 20854 Euthemia Protos/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4-18-06 4 ☐ Donation 5 ☐ Other (Specify) Washington DC Glenwood Cemetery 21. Signature of Funeral Sergice/Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC any tr 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, of complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician nknown /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien end s the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as ettending f IF FEMALE: USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ed by the deteched 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performed? 1 ☐ Yes 2A No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s hes certificete Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? spital: Inpatient 2 28a. Date of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ဥ 1 🗌 Yes 2 ER/Outpatient 3 DOA After this 27. Magner of Death 1 A Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending Injury deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer M.D. D0062653 April 14, 2006 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLMES 9901 Medical Center Drive, Rockville, MD ROBERT RYAN 31. Date filed (Month, Day, Year) egistrar's Signature State **APR 18** 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eleanor **Physician** Berna Pasch April 14^{pay} 2006 2:15A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) July13, 1925 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Oh10 **Funeral** 291-20-3402 1 ☐ M 2 💢 F 80 Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits worle permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itama 23a or 28a-1 ahov any injury or other traumatic event, the Medical Examinar must be notified at once. Maryland Prince George's Silver Spring 1 Yes 2 No Directo 10e. Street and Number 3152 Gracefield Road, #223 10g. Citizen of What Country?
United States 10f. Zip Code 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Executive Assistant Real Estate 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Tell Berna Katherine Wilby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3152 Gracefield Road, #223 Silver Spring, Md. 20904 Alan Pasch -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 4/15/2006 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 oreld 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Respiratory Failure 72 hours /Medical Due to (or as a consequence of): Examiner Ovarian Carcinoma w/lung metastases 5 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 TNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ir this certificete has b eral director, page 2 si autopsy performed' 1 Yes 2 No 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Knpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation To the Hospital or Attendir within 24 hours efter death.

To the Funerel Director: At completely filled in by the fur М 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D22780 April 15, 2006 30. Name and address of Frson who completed cause of death (Item 23a) (Type, Print)
Peter M. Schissler, M.D. 7500 Greenway Center Drive Greenbelt, Maryland 20770

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 1 8

32. A gistrar's Signature

2006

			For State Ragistrar		State	of Maryla		artment of H		Mental Hy	giene Reg. Ne. 0	16	13860
	Physici /Medic		1. Decedent's Name	(First, Middle,	•	nnie M. I	Parker			2. Date of De Month	Day 0r 12, 2006	Year	3. Time of Death
	Examin		4a. Fecility Name (If		give street and i				r Location of Death ince Frederic		4c. Count	y of Death Cal	
*	Funeral Director		5. Social Security Nu 216-80-05	72	6.Sex 1 □ M 2 X 0 F		rs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bii (Month, Da Jun 2	th ay, Year) 9, 1920		place (State or Foreign ntry) Maryland
Pool of the	f ehow	or	Usual Residence of 10a. State	10b. County	Calvert	10c.	City, Town or L		Port Republic			1	10d. Inside City Limits 1 ☐ Yes 2 🙀 No
di di	3a or 28a-	Funeral Director	10e. Street and Num	nber				10f. Zip Code	20676		10g. Citizen of	What Cour	·
000	s I and 2 should be tied within 72 hous alter beath with the maryland. The auth and Mohal Highen "Heat" is the standard other than "naturel", or fleme 23a or 28a-f show other traumatic event, the Madical Examinations housilled.	by	11. Marital Status 1 Never Marrie 3X Widowed		Armed 1 Te If Yes,	ecedent Ever in Forces? s 2 💟 No Give r Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Bla	ce - Americack, White,	etc.
0-C1717	giene. pr than "natu	Completed	(Speci Elementary/Secon		grade complete	ed) (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired Dor	during most of work	king	16b. Kind of E		e's Home
אומות	stroug be then with the strong of the strong	To Be C	17. Father's Name (a	First, Middle, L	•	Wallace			18. Mother's Nam		ie Commo		
~	Health and I Healt		19a. Informant's Na Dianne Stev	wart/Daugl		100	P.O.	Box 327 Port		20676			<u> </u>
	rage nent o ant: If ary or		4 Donation	☐ Cremation 5 ☐ Other (Sp.			Greater B	osition (Name of ematory or other place lible Way Churc	h -04/	7/06 1/8/06	20c. Location		erick, MD
0	Departr Importa		21. Signature of Fur	ye a	See	ell		1451 Dar	uneral Home res Beach Ro			MD 206	Approximate
	hysician /Medical		shock, or heer Immediate Cause (I disease or condition resulting in death)	t failure. List o Final	a	n each line.	mra	nter the mode of dyin					Interval Between Onset and Death
	xaminer	ner	Sequentially list con if any, leading to im-	mediate	b. A	to (or as a cons	equence of):	nte Pulling To	jelonep	hyta		,	yeur
0,00,	physicien and sthe burial-transit	dical Examiner	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		c. Due	to (or as a cons		14ths 13	L - Insu	LM deg	peneleni	<i>T</i>	yours
O. DOX OC	To the nospital of Attenuing Frigstoans. The law requires that beart centure within 24 hours after deep deep the within 24 hours after deep after this certificate has been signed by the attending placompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 € 1 □ Yes 2 ♥ 9 □ Unknown	months?	1 Liv	outcome of prege birth 2 Feegnant at time oknown	etal death 3	□Ectopic pregnancy	,			ate of delive	ery Day Year
rus, r	quires triat in signed b uld be deta	by	Part II. Other signification	cant condition	s contributing to	death but not r	resulting in the	underlying cause giv Renal Fi nHa	en in Part I.		tobacco use con Yes 2 No	3 Prot	he cause of death? Dably 4 DUnknown
II necords,	cate has bee	Completed	Anorex	ta /	Vers	enter	Deme	ntla				Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
סו אוושו	rnysician r this certifi ral director	To Be	25. Was case referrexaminer? 1 Yes 2 2 1 27. Manner of Death	No	28a. Da	te of Injury	ER/Outpatie		4 🗆 Mul Sing 11	ome 5 Res	one) idence 6 □Ot how injury occu		(y)
LIVISION	or Attending after death. Director: Afte in by the fune	ertification:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation of Could not determine	ot be 28e. Pla	ace of Injury - Aliding, etc. (Spe	t home, farm, s		k? Yes 2 □No		(Street and Num wn, State)	ber or Rura	al Route Number,
	e nospital 24 hours a Funeral a stely filled	edical Ce	29a. Certifier (Check only one)	1 Certifying 2 Medical E	xaminar: On the	the best of my keep basis of examination	knowledge, dea ination and/or i	th occurred at the tir nvestigation, in my o	ne, date and place, pinion, death occur	, and due to the rred at the time,	cause(s) and m	nanner as s , and due to	itated. o the cause(s)
	within To th	Me	29b. Signature and	title of certifier	P. Sta	time	MD	29c. Licens	7245		29d. Date signo	ed (Month,	Day, Year)
	4			Sterner, M	M.D.	Prince Free	derick, MD	20678					
	Sta Registr		31. Date filed (Mont	APR	1 3 2005	Registry's Sig	gnature #	pole					

DHMH 17 Rev 1/2001

Funeral Director 5. Social Security Number 5. Sex 7. Age (In yrs. last birthday) 15 Under 1 Year 16 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 19, 19	County of Deeth UCONINGHO
Funeral Director 5. Social Security Number 219-14-7380 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 81 Yrs. 1 Months Days Hours Min. Whin Days Hours Min. Feb. 19, 19	Vaoninghin
Usual Residence of Decedent	Country
	925 West Virginia
O Maryland Flochington Vocation 11	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Maryland Washington Keedysville 10e. Street and Number 10f. Zip Code 10g. Citi	tizen of What Country?
19134 Shepherdstown Pike 21756 11. Marital Status 218. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian,
10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. Street and Number 10d. Zip Code 10g. City 10d. Zip Code	Black, White, etc. Specify: white
3 Widowed 4 Divorced If Yes, Give 1949-53 1 Yes 2 No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16b. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of work done during most of working life. DO NOT use retired) 16c. Kind of working life. DO NOT use retired) 16c. Kind	(ind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) heavy equipment operator To provide the secondary (0-12) To provide the secondary	oad construction
Philip Pratt The Father's Name (First, Middle, Maiden) Philip Pratt Philip	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Perint) Perint Portion 19b. Mailing Address (Street and Number or Rural Route Number, City or P.O. Box 238, Keedysville, Mary)	
The first of the f	ocation - City or Town, State
4 Donation 5 Other (Specify) 1	liamsport, Md. TNERAL HOME
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Interval Between Onset and Death
/Medical resulting in death) Due to (or as a consequence of): Examiner	y n
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
Due to (or as a consequence of): Cause. Enter Underlying Lause Lisease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.	
Sheet seems of the	Yipi daga atau a
C. Due to (or as a consequence of): Comparison of the part of t	23d. Date of delivery Month Day Year
O detail. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 A Leave To a le	use contribute to the cause of death?
Anterior actions and property of the part	No 3 Probably 4 Winknown 24b. Were autopsy findings available
244. Was an autopsy performed? 1	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 Fr/Outpatient 3 DOA 1 No 1 Inpatient 2 Fr/Outpatient 3 DOA 1 No 1 Inpatient 2 Fr/Outpatient 3 DOA 1 Inpatient 2 Fr/Outpatient 3 DOA 1 Inpatient 3 DOA 1 Inpatient 3 DOA 1 Inpatient 4 Inpatient 5 Residence 10 DOA 1 Inpatient 2 Fr/Outpatient 3 DOA 1 Inpatient 3 DOA	6 □Other (Specify)
The state of the s	
Control of the contro	nd Number or Rural Route Number, e)
29a. Certifier 20a. Certifier 20a. Certifier	
29b. Signature and title of certifier 29c. License number 29d. Date 29d. Date	ate signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	21740
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature DHMH 17 Rev 1/2001	

		•	For State Registrar		aryland / De		t of He	ealth an	nd Mental		UU	6	13862
ı	Physici /Medic	100	Decedent's Name (First, Middle, Last) Judy Carolyn PALM						2. Date A PR	of Death	Pay o	2006	3. Time of Death 5:56 AM
	Examin		4a. Facility Name (If not institution, give					_ocation of [Death		4c. County		
			Washington County 5. Social Security Number 6. Sex		e (In yrs. last birthda		<u> </u>	If Under 24	Hrs. 8. Date	of Birth		ingt	
46	Funeral Director		220-42-5316		60 Yrs.	Months	Days		Min. (Mon.	of Birth th, Day, Yea h 26,	1946	Ma	place (State or Foreign ntry) ryland
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	Maryl 1 sho	ţō	Maryland Washing	gton		Smiths	burg						1 ☐ Yes 2X No
	h the	irec	10e. Street and Number			10f. Zip				10g.	Citizen of V	What Cou	ntry?
	23a c	al D	14020 Wolfsville	Road				217	83		U	SA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f ehow any figury or other traumatic event. The Medical Examinatibe Indiffied at ADES.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	Ever in U.S. 13	Was Deced If Yes, spec		panic Origin , Mexican, F Specify:	i? (Specify Yes Puerto Rican, et	or No- c.)	Blac	e - Americk, White,	
20	72 ho	sted	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dec	edent's Usua	ai Occupat	tion urina most o	f working	16b.	Kind of Bu	usiness/In	dustry
21	ithin 19.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	e kind of wor DO NOT us	se retired)	ang most o	, woming				
2	tygier her th	Ö	17. Father's Name (First, Middle, Last)	0	C	ook		18 Mother's	Name (First, M		resta		τ
lanc	ild be fi fental F rked ot tic ever	To Be	Elmer Leon McAfe	е					ine Mil		en Suman	10)	
Maryland	12 shour and N is mai		19a. Informant's Name/Relationship (Ty						or Rural Route I				
re,	s 1 and f Health item 27 other t		Steven G. Palmer - 20a. Method of Disposition		20b. Place of Dis				., Smit	-			nd 21783 own, State
Baltimore,	Page ment o tant: if lury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		St. Marl	k's Lu	thera	ın 📒	4/20/06	_			Maryland
Balt	permit. Depart import any inj		21. Signature of Funeral Service Licens	Mus	mil	22. Name an			MI lvd., H	NNICH agers			
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition	ne cause on each lir	the death. Do not ene.					tory arrest,			Approximate Interval Between Onset and Death
-35	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								
64	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):			<u> </u>					
o,	ate be executed hysician and the burial-transit	Exar	that initiated events resulting in death) Last	·	a consequence of):	DRUSC	.				-		
68760,	physic s the bu	dical		1									
.O. Box	Attending Physicien: The law requires that the death certifics reads. rdeath. actor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be delached for use as it by the funeral director.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	Ectopic pr						te of deliv	ery Day Year
<u>а</u>	uires that signed b id be deta	d by PI	Part II. Dther significant conditions cor			underlying c	ause givei	n in Part I.	23e.				he cause of death?
COL	w requir been si should	ete	Palmonary FIB		_	IT AC	PIRA	rinal	24a.	Was an	24b. ¹	Were auto	opsy findings available
of Vital Records,	: The lav	Comp								autopsy performed Yes 2/2	, !	prior to co death? 1 🗌 Yes	empletion of cause of
<u> </u>	sician: Th certificate rector. pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital:			Other		Death (Check		- 7		
on of	iding Physician: th. : After this certifica s funeral director.	itlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatie 28a. Date of Inju (Month, Day	ry 28b. Time		8c. Injury Work	4 1140131		Residence			fy)
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, farm, c. (Specify)	street, factory	/, office			tion (Street or Town, St		er or Rur	al Route Number,
	ne Hospital or n 24 hours afte ne Funeral Dir bletely filled in	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of and manner sta	of my knowledge, de f examination and/or ated.	ath occurred investigation	at the time , in my opi	e, date and p inion, death	place, and due to occurred at the	to the cause time, date a	(s) and ma and place,	anner as s and due t	stated. o the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			290	. License				_		Day, Year)
)			Madran Hub				(m)	-	2				
	4.01		30. Name and address of person who co								NGTU	N CO	UNTY HOSPITAL
	H-4 Sta	10	31. Date filed (Months Days Year)	32 Benietr	ar's Signature			KTLAN	UD 21	740			
	Sta Registi	ar	31. Date filed (Month Pay Year) 8 20	106 Since	in Signature	pade	,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Jane Parry 1228 2006 tori /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL NIONNICO SALBBUT Medicol If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/15/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Davs Hours 1 M 2 F 85 139-14-9702 Director Pennsylvania Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Booth St. 21801 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes X☐ No white If Yes, Give Year or Dates: Specify: Specify: 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natt any injury or other traumatic event, Ita Medical ODEs! Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanche Kimble John Mustard ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Parry / daughter 402 Elberta Ave., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bethel Memorial Park 4/21/06 Pennsauken, NJ 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22 Horroways Funeral Home Professional Association 501 Snov Hill Rd., Ealisbury, MD 21804 David H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** THERD SCLEROTI /Medical Due to (or as a consequence of) Examiner Sequentiary list sonditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and Due to (or as a consequence of) Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificete hes 1 Yes After this certification funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 □ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Function (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) EASTERN SHAREDK SALISBURY 32. Aggistrar's Signature State Registrar

39-17-970

Maryland 21215-003

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of M	arylan				ealth and Death	d Mer		iene g. No.	006	13854
	Physici	· .	1. Decedent's Name (First, Middle, La	st)							Date of Deatl		Year	3. Time of Death
	/Medi		Fannie			Pol	ansk				oril 22	1		4:54pm м
	Examir	ner	4a. Facility Name (If not institution, give						Location of Di				County of Dea	
- 19		. 2	Vindobona Nursi		(10 110	iast birthday)		CADDO or 1 Year	ck Heig		Date of Birth	Г	rederi	
*	Funeral Director		5. Social Security Number 106-16-6172 Usual Residence of Decedent	I M 2 X F	95	,,	Months			Ain. A	Month Day,	1910) Ch	thplace (State or Foreign ountry) iina
	•how		10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Limits
	Many	tor	Maryland Freder	ick		Bradd	ock 1	Heigh	its					1 ☐ Yes 2 🔯 No
	h with the	al Director	10e. Street and Number 6012 Jefferson	Blvd			10f. Z	p Code 21	714		10	_	en of What Co	ountry?
5-0036	172 hours after death with the Maryland "natural", or itame 23a or 28e-1 show adical Exarturational be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 XI If Yes, Give Year or Dates:	?				ispanic Origin? n, Mexican, Pu Specify:	? (Specify uerto Rica	Yes or No- an, etc.)		4. Race - Ame Black, Whit Specify:	
21215-(within 72 h 8ne. than "natu he Wedical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		5+)		dent's Us kind of w DO NOT emak	ork done d use retired	ation during most of ()	working			of Business. Own Hom	16
Maryland 2	ges 1 and 2 should be filed within 72 hc it of Health and Mental Hygliene. If Item 27 is marked other than "nature or other traumatic event, the Medical	To Be Co	17. Father's Name (First, Middle, Last Unkown)					18. Mother's Hann		irst, Middle, N	Maiden S		Kantor
lary	and N		19a. Informant's Name/Relationship	1.					and Number or			-		
	and sealth m 27		Mrs. Anne Mellon	/Daughter	1001.0	_	HIS SAME THE THE SAME							and 21702
Baltimore,	ges 1 and t of Health if item 27 or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [Removal from State	20b. F	Place of Dispo cemetery, crei	natory or	other plac	e)	Date			ation - City or	
Ë	tent:		4 □ Donation 5 □ Other (Speci		Ar					y May	, 9,	006	Fort M	yer, VA
Bai	permit. Page Department (importent: If any injury or ang injury or		21. Signature of Fureral Service Lice	Been	MOO:	706	Name a Ke Ob E	eney est C	ss of Facility A Basfo hurch	grd	A. Fi	mer ick.	al Hon Maryl	e and 21701
	Physician		23a. art1. Enter the disease, or con shock, or hear failure. List only Immediate Cause (Final disease or condition	one cause on each I	ine.	h. Do not ent zheime	er the mo	de of dyin	g, such as care	diac or re	spiratory arre	est,		Approximate Interval Between Onset and Death Years
8760,	Medical Examiner physician and the burial-transit	lical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as	a conseq	uence of):								
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death 3	Ectopic Other (oregnancy specify)				2	3d. Date of de Month	livery Day Year
Ω.	uires that signed b id be deta	by	Part II. Other significant conditions Recurrent Aspi		out not res	ulting in the u	nderlying	cause give	en in Part I.					o the cause of death?
Records,	e law requir has been si ge 2 should	Completed	Large Hiatal H	lernia						_	24a. Was ar autops perform	Y	24b. Were a prior to death?	utopsy findings available completion of cause of
a	- in			1							1 ☐ Yes 2	X No	1 ☐ Yes	2 □ No
of Vital	Physicien: this certificand director,	Be	25. Was case referred to medical examiner?	Hospital:	00	I EDIO . I		Othe	05		heck only on			
of		1: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Inju		ER/Outpatier 28b. Time o		28c. Injun World	4 M IAMISII		. Describe ho		Other (Spe	ecify)
Division	I or Attending Faffer death. Director: After In by the funer.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not l 4 Homicide determined	n OB Blood of to	ijury - At h	ome, farm, str	M reet, facto	1 🗆 '	k? Yes 2 □ No	28f.	Location (Sti City or Town		l Number or R	ural Route Number,
J	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce		hysician: To the best miner: On the basis of and manner st	of examina									
	To th withir To th comp	Me	29b. Signature and title of certifier	. 0			2	9c. License	e number		29	9d. Date	signed (Mon	th, Day, Year)
			Kathleen	W Sen 1	3			D32	073		A	Apri	1 25,	2006
			30. Name and address of person who Kathleen W. Ste					ıe, B	runswic	ck, N	Marylar	nd 2	1716-18	828
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist		ature								

DHMH 17 Rev 1/2001

15/Mc

		•	For State Registrar		State of M	aryland / i		rtment of H		nd Ment		ene 3. No. 0 0 6	13865
			Decedent's Name	e (First, Middle,	Last)						ate of Death		3. Time of Death
	Physici		Thelma	Cather	ine Quilli	n				1	Month ~	183 200	(124) AM
	/Medio Examir		4a. Facility Name (I		give street and number)			4b. City, Town, or	Location of [Death	7-0	4c. County of Deal	
			Baltimor	e Washi	ngton Med.	Center		Cherl	ner	(del)		Asie	Anusel
	Funeral		5. Social Security N		6. Sex 7. Ag	je (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under 24 Hours		ate of Birth	(ear) 9. Birt	hplace (State or Foreign
	Director		577-68-80		1□M 2 X 0F	75	Yrs.	Wichtins Days	riours	Dec	. 16,		ryland
	pu k		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Tov	m or Loc	ation					10d. Inside City Limits
	eho	5						Park					1 ☐ Yes 2 🛣 No
	with the Maryland a or 28e-f ehow	Director	MD 10e, Street and Nur		rundel	Sev	erna	10f. Zip Code			100	g. Citizen of What Co	huntov?
	after death with the Marylan or itema 23s or 28e-f ehow miner must be notified at	Ö		ickhouse	, DA			2114	6			USA	only:
	death ma 23	Funerai	11. Marital Status	CKHOUSE	12. Was Decedent	Ever in U.S.	13. W	/as Decedent of Hi Yes, specify Cuba		n? (Specify \	Yes or No-	14. Race - Ame	nican Indian,
(0	riten	ᇤ	1 ☑ Never Marri	ied 2 Marrie	Armed Forces?)				Puèrto Ricar	n, etc.)	Black, Whit	e, etc.
93	hours after urel', or ite	þ	3 Widowed	4 Divorced	If Yes, Give Year or Dates:		1	☐Yes 2DXNo	Specify:			Specify: WI	nite
21215-0036	72 ho	Completed	(Spec	15. Decedent's	s Education grade completed)	16a	. Decede	ent's Usual Occupa	ation	f working	16	6b. Kind of Business	Industry
126	ithin	du	Elementary/Seco		College (1-4or	5+)	lite. D	O NOT use retired)				
2	led w		7 17. Father's Name	(Fine Addition)	- 0				40.14-4-4-		none	aiden Sumame)	none
Maryland	d ot	Be	_									alden Sumame)	
₹ <u>₹</u>	d Mer mark matic	ဥ	Jesse 19a. Informant's Na	2.	illin	10	h Mailine	Address (Street		Mae Ho		City or Town, State, 2	Zin Code)
N S	d 2 s Ith an 27 is trau		Cathy He	,	neice		•	Caswell			ie, MD		
20	Hea Hea tem		20a. Method of Disp		10100	20b. Place of	f Dispos	ition (Name of		Date		Oc. Location - City or	Town, State
30 OF	Pages ent of nt: # i			☐Cremation 5 ☐ Other (Sp.	3 □Removal from State ecify)		•	atory or other plac	· 1	1/21/2	006 8	uitland, 1	MD
7HBL altimore,	permit. Pages 1 and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; , amy injury or other traumatic avent, <u>Tra Madical Examonce</u> .		21. Signature of Fu			, ccuai		Name and Addres	-			al Home	,ш.) •
ä	Depariment of the part of the) e	Bus	Touch	1	65	12 NW Cr			Bowie,		15
			23a. Part1. Enter the	ne disease, or o	complications that caused only one cause on each li	d the death. Do	not ente	r the mode of dyin	g, such as ca	rdiac or res	piratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (disease or conditio	(Final	()	Recy 5	١, , ,						Onset and Death
	/Medical		resulting in death)	ï		a consequence		<u></u>					weeks
	Examiner		Sequentially list co.	nditions	b								
	₽ ≒	Examiner	Sequentially list con dany, leading to in cause. Enter Unde Cause (Disease or	imediate orlying	Due to (or as	a consequence	rof)r						
	be executed ician and burial-transif	cam	that initiated events resulting in death) I	5	c.	a consequence	o4):						
8760,	cate be executed physician and the burial-transit	alE			200 10 (0) 43	a consequence	01).						
687	ficate physics the I	dical			d.								
Вох	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome	of pregnancy		LITTLE STATE				23d. Date of del	ivery
	death e atte	cla	in the past 12	months?	4☐Pregnant a	2 Fetal death		Ectopic pregnancy Other <i>(specify)</i>			-	Month	Day Year
P.0.	thet the de led by the a deteched t	hys	9 Unknown		9□ Unknown								
Α,	es the igned be det		Part II. Other signif	icant condition	ns contributing to death b	out not resulting	in the un	derlying cause give	en in Part I.	1	23e. Did toba	cco use contribute to	the cause of death?
ğ	w require been sig should b	ed	Mys.	e/fer	Bur, D	Abset	0 -	ATRICAL		_	1 🗌 Yes	2 □ No 3 □ Pr	obably 4 donknown
သိ	12 S 20	Completed by	- Fish	will	Two					2	24a. Was an autopsy	24b. Were at	itopsy findings available completion of cause of
Œ.		E O								1	performe	ed? death?	2 No
ita	Physician: Th this certificete ral director, pag	Be (25. Was case refer examiner?	red to medical						f Death (Che	eck only one,)	
Ť	Physic this c	၉	1 ☐ Yes 2 €		Hospital: 1 npatio			3□ DOA Oth	4 🗆 INUISI			ce 6 ☐ Other (Spe	cify)
n c	After I	inol in	27. Manner of Deat	5 Pending		ury 28b. uy Year)	Time of Injury	28c. Injun Worl			Describe how	v injury occurred	
isio	Attending r death. ector: After by the fune	icat	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	ot be Goo Blace of la	ium. At homo f			Yes 2 □ No		nonting (Stre	et and Number or Ru	m I Pauta Number
Division of Vital Records,	after Direction by	Certification;	4 Homicide	determin	28e. Place of In building, et	tc. (Specify)	arm, stre	et, actory, office			City or Town,		arai noble Number,
_	lospitet hours a unerei C		29a. Certifier	12 Certifying	Physician: To the best	of my knowladg	e death	occurred at the fin	io Jate and o	plane, and d	ue to the day	isels) and infantier as	betete
	To the Hospitet or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai	(Check only one)	2 Medical E	xaminer: On the basis of and manner st	of examination as	nd/or inv	estigation, in my of	oinion, death	occurred at	the time, dat	e and place, and due	to the cause(s)
	To the To the Comp	ž	29b. Signature and	Title of certifier	7		2757	29c. License	number		290	d. Date signed (Mont	h, Day, Year)
				anie	lela	eren_	~	_ 0 -	467	61	A	Pril 15	TH 2006
00	(2)	- 8	30. Name and addr	ess of person v	who completed cause of o	death (Item 23a)	(Type, F	rint) DA	fues	and	any	cron-	
CR			31. Date filed (Mon	TOL H	32. Begiste	rar's Signature	- 6	Ren/	rexue	ie a	20 0	1061.	
难	Sta Registi		T. Date med (Mon			Lar a Gignature							
		1	A	rk 19	2006 Dece	e F	42						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month April 17, Year Louise Gall Rover 2006 12:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick
If Under 1 Year III Under 24 Hrs.
Months Days Hours Min. Frederick Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 💢 F 96 Vrs 212-38-8723
Usual Residence of Decedent Maryland Director Jan 25,1910 with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 Tx No Frederick Thurmont Maryland Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21788 USA 14836 Sabillasville Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other traumatic event 20x8: 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elizabeth Gal1 Lottie Creeger Carl Stanley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14844 Sabillasville Road, Thurmont, MD 21788 Rebecca Urian/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/2006 Blue Ridge Cemetery Thurmont, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Utenese 22. Name and Address of Facility Stauffer Funeral Home, PA 104 E. Main Street, Thurmont, MD 21788 23a. Part1. Externe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PulmonAry Embolism Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? 1□ Yes 2 No Be director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation within 24 hours after deat To the Funerel Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061172 4-18-06 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seventh Street, Frederick, MD 21701 400 W. Ronnie Jacobs Registrar's Signature 31. Date filed (Month, Day, Year) APR 1.8 2006 State Registrar

			1 - For State Registrar	State	of Marylar		artment of I rtificate of	Health and <i>Death</i>	Mental Hy	rgiene () ()6	13867
	Physici	an	Decedent's Name (First, Mide		D.T. GW DOWN	a			2. Date of Do	eath	Year	3. Time of Death
	/Medi	cal	PATRICE BERN 4a. Facility Name (If not instituti		RICKETTS	5	4h City Town	or Location of Dea	April	14, Day 2006		9:30 AM
	Examir	ner	19300 Muncast		umbery		Derwo			Mont		у
	Funeral Director		5. Social Security Number 220–49–5978	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. 20	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi	79, 1986	9. Birthp Coun Jama	place (State or Foreign atry) alca
	and w		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Cit	ty, Town or Lo	ocation				1	0d. Inside City Limits
	Maryla -f aho	tor		gomery		erwood						1 ☐ Yes 2 X No
	or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?
	ath wi	ral	19300 Muncast				208			Jama		
36	n 72 hours after death with the Maryland *natural, or Itema 23a or 28a-f ahow calcal Examinations be notified at	by Funeral	11. Marital Status 1 X Never Married 2 Ma 3 Widowed 4 Divorce	Armed F	2 MNo live		Was Decedent of If Yes, specify Cub 1☐ Yes 2፟X No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		k, White,	ean Indian, etc. .ack
121	_	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12	est grade completed	(1-4or 5+)	(Give	DO NOT use retire	during most of wo	rking	16b. Kind of Bu		•
Maryland 2	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle	, Last) Cetts				l _	me (First, Middle Lawrence	, Maiden Sumam		
lary	2 should and Men is marks sumatic	Г	19a. Informant's Name/Relation					t and Number or R				Code)
€, ₹	2 - L - 2		Donna Lawrence	(Mother)	20h 5	-1-1-1	0 Muncas	ter Road	Derwoo	d, Md. 2		Ctata
Baltimore,	permit. Pages 1 and 2 should Depertment of Health and Men Important: if Itam 27 is marke eny Injury or giher treumatic onge.		1 ∏Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	State	semetery, crei 1 Soul	matory or other pla s Cemete	ry Apr	cil 22,	Germant	own,	
Bal	Depermit Deper Impor eny Irr		21. Signature of Funeral Service	1 De		. 1	lO East I	ess of Facility De Deer Park	Dr. Ga:	Lthersbur		d. 20877
	Physician / Medical Examiner buvision and physicien and ph	edical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	ab	o (or as a consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence of (or a) consequence	yence of):	Seicul					Interval Between Onset and Death
P.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phraid director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Peta gnant at time of d	Il death 3	∃Ectopic pregnand □ Other <i>(specify)</i> _	ey		23d. Date Mor	e of delive	ory Day Year
S, D	es that igned b be deta	by Pt	Part II. Other significant condi	tions contributing to	death but not res	ulting in the u	nderlying cause g	ven in Part I.		_		ne cause of death?
ord	w require been si should I	eted	_cerebral	palsy	/				10			ably 4 Unknown
of Vital Records,	The law cate has b page 2 s	Completed							24a. Was auto perf 1 Yes	s an 24b. V pormed? d	Vere autor Fior to cor eath?	psy findings available mpletion of cause of 2□ No
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medic examiner?	Hospital:			0:	hom	ath (Check only			
ion of	nding Phys th. : After this s funeral di	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves	28a. Date		ER/Outpatier 28b. Time o Injury	Time of 28c. Injury at 28d. Describe how injury occurred)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could	mined 200. Flat	e of Injury - At hi ding, etc. (Specil	ome, farm, str	reet, factory, office			(Street and Number wn, State)	er or Rura	l Route Number,
	To the Hospitei within 24 hours a To the Funerai I completely filled	Medical (29a. Certifier 1 Cartify (Check only one) 1 Madica	ing Physician: To the Il Examinar: On the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)
	J/	M	29b. Signature and title of certif	Hut	MD		Doo	se number 94487		29d. Date signed	200	26
	<i>V</i>		30. Name and address of person Debrok Hilk M	n who completed cau	use of death (Iter Execut	n 23a) (Type,	Bivd.	Rock	ville R	ld 208	92	
1	Sta Regista		31. Date filed (Month, Day, Yea APR 1	8 2006 32.	Megistrar's Signa	ature	marke					

			For State Registrar	State of Ma		partment of F ertificate of		Mental Hyg	jiene	6 3868
8	Physici		Decedent's Name (First, Middle, Las James Russe		apaugh			2. Date of Dea Month April 1	th Day	3. Time of Death 3:30 p M
	/Medio Examir	14	4a. Facility Name (If not institution, give	street and number)	apaag	4b. City, Town, o	or Location of Dec		4c. County	
	Funeral Director		577-50-8926	X 7. Age	(In yrs. last birthda) 67 Yrs.	Months Days	If Under 24 Hi Hours Min		Year) , 1938	9. Birthplace (State or Foreign Country) Washington, DC
	death with the Maryland ms 23s or 28s-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Arun		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a	Director	10e. Street and Number			10f. Zip Code			l 0g. Citizen of 1	What Country?
	in 72 hours after death with the Marylan "natural", or itama 23e or 28e-f show socieal Eveniner must be notified at	by Funeral	124 Konrad Morgan 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Way 12. Was Decedent E- Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:		20° Was Decedent of H If Yes, specify Cub	dispanic Origin? an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Rad Blad	S.A. be-American Indian, ck, White, etc. white
1215-0036	filed within 72 hou Hygiene. Ither than "natura int, Ira Madical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retire	during most of w d)			usiness/Industry
È	be d la la	To Be Co	12 17. Father's Name (First, Middle, Last) John Owen Rul	apaugh	50	ceam fitte		ame (First, Middle,	Maiden Surnan	
Ž	d 2 shouth and N		19a. Informant's Name/Relationship (7) Richard A. Rulapau			iling Address (Street				State, Zip Code) Le, MD 21617
	Page nent o ant: If ury or	-	20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			oosition (Name of ematory or other pla Ltan Crema	· I	_18-06 A		City or Town, State
Dall	permit. Departr Importa		21. Signature of Funeral Service Licen	Testo	ed I		neral Ho			s, MD 20736
	Physician /Medical Examiner		23a. Part1. Enter the dispase, or come shock, or heart tailure. List only of immediate Cause (Final disease or condition resulting in death)	a. CHOWC bue to (or as a).	EUCTIVE				Approximate Interval Between Onset and Death
grou,	the death certificate be executed y the attending physicien and tched for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
O. BOX 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	☐Ectopic pregnanc	у			tte of delivery onth Day Year
cords, P.	w requires that been signed by should be deta	ρ	Part II. Other significant conditions of	entributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did to		tribute to the cause of death?
	The la ate has page 2	Completed	ELEVATED CHE	LESTERO				24a. Was a autop perfor 1 Yes	med?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital	sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:		Ott		eath (Check only or		
on or	or Attending Phys after death. Director: After this in by the funeral dis	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		of 28c. Inju Wo	ner: 4 Nursing ry at rk? Yes 2 No	Home 5 Resid	ence 6 Oth	
DIVISION	af or Attendi s after death. Il Director: A sd in by the fu	Certification;	3 Suicide 6 Could not be determined		ry - At home, farm, s (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	ber or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	edical		/sician: To the best of iner: On the basis of and manner stat	examination and/or	investigation, in my	opinion, death oc	curred at the time, o	late and place,	and due to the cause(s)
	Vith To 1	Z	29b. Signature and title of certifier	\wedge		29c. Licen:	2906		29d. Date signe	Month, Day, Year)
8	+\ Sta	ate	30. Name and addless of person who described to the state of the state	M.D., 12	2070 old		tre # 20	7, Waldor	f, MD 2	20602

			1- For State of Maryland / Dep	eartment of Health and I	Mental Hygier	
4	8		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici	-200	James Briscoe Robinson, Jr.			2006 Year /530 M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Lxaiiiii	101	2240 Lowery road	Untingtorn		Co leaset
£ .	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Huntingtown If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Calvert 9. Birthplace (State or Foreign Country)
	Director		218-30-4907 X 2 F 73 Yrs.	Months Days Hours Min.	July 8 193	32 Maryland
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	acation		10d. Inside City Limits
	the Marylar 28a-f show notified at	اجا				1 Yes 2 No
	Ba-f	ecto	Maryland Calvert Huntin		100	Citizen of What Country?
	with t	급	10e. Street and Number	10f. Zip Code		
	s 23a	era	2240 Lowery Road 11 Marital Status 12. Was Decedent Ever in U.S. 13	20639 Was Decedent of Hispanic Origin? (S		ited States 14. Race - American Indian,
	Items	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 X2 Yes 2 □ No	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
336	urs aft	Ď	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No Specify:		Specify: white
5-0036	72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show idical Examinat must be notified at	Completed		edent's Usual Occupation	16b.	. Kind of Business/Industry
215	within 7 ene. than "n	ple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	King	
2121	gient gient	NO.		nter/farmer		nstruction/ agricultu
	al Hygid of other	Be	17. Father's Name (First, Middle, Last) James Briscoe Robinson, Sr.		ne (First, Middle, Maid Gatton	en Sumame)
yla	should be ind Mental I	ဥ	•			
Maryland	C1 10 - 42		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ru	ural Route Number, Cit	y or Town, State, Zip Code)
	1 and Health em 27		Joan Robinson- wife 2240	Lowery Rd. Hunting	gtown MD 20)639
ore	Pages 1 nent of H int: If ite			ematory`or other place) April 1	19 2006	Location - City or Town, State
Ë	Pag ment ant: lury		4 Donation 5 Other (Specify) Metropol	itan Funeral Servi		exandria Virginia
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.				Rausch Fune	
_	ಪರ್ವ ತ			405 Broomes Is. Ro		
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	c or respiratory arrest,	Approximate Interval Between Onset and Death
Jane 1	Physician		Immediate Cause (Final disease or condition	Antery Dr.	Spore	Criset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):)		
	LAGIIIIIEI	_	Sequentially list conditions, b.			
195	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	and -trans	Kam	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	E	Sub-to-(of as a consequence of).			
87	physi the t	dlcal	d			
9 x	E O G	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			COAL Date of delicery
Вох	that the death cer ed by the attendin detached for use	lan	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	the de	yslc	1 Yes 2 No 9 Unknown	Other (specify)		
٥.	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
of Vital Records,	uires than signed I Id be det	Completed by	Unserviced Cardiac Pace	maker	1 ☐ Yes	2 No 3 Probably 4 Hunknown
Ö	w requir been si should	ete			24a. Was an	24b. Were autopsy findings available
Rec	has has ge 2	E G			autopsy	prior to completion of cause of death?
<u>_</u>	ician: Th certificate rector, pag	ပိ	25. Was gase referred to medical		1 ☐ Yes 2 ☐	No 1 ☐ Yes 2 ☐ No
₹	Physician: this certific ral director,	100	examine 1 May 96 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor	ath (Check only ope) Home 5 Residence	6 DOther (Coords)
ō	Phys r this ral di	: To	27. Manyer of Death 1 (Wonth, Day Year) 28. Date of Injury (Month, Day Year) Injury		28d. Describe how in	
Division	Attending r death. ector: Atter by the fune	tlor	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
is!/	dea ctor	flca	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, s	street, factory, office		and Number or Rural Route Number,
D.	after Dire	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
	ne Hc	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.	mestigation, in my opinion, death occu	urred at the time, date a	and place, and due to the cause(s)
	To the within To the comp	¥	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	_		1/1/6/1//	111324		April 18, 2006
			30 Name and address of person who completed cause of death (Item 23a) (Type	a, Print)		1
	6+1		31. Date filed (Month, Day, Year) APR 1 8 2005	32 Con Rd	Hunt	(IN mot of
Š	St	ate	31. Date filed (Aonth, Day, Year) 32. Registra's Signature	And S		0
	Regist	rar	APR 1 8 2005 Messure St.	The series		

burial-transit and

attending physician for use as the burial signed by the a should peen page 2 s certificate this After death. Director:

Division of Vital Records, P.O. Box 68760

Physician:

To the Hospital or Attending within 24 hours a To the Funeral D mel

State

Registrar

CUMBERLAND, MD 202 Greene Street Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dement Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wowockisten MD 00055325 APLI 12,2006

DHMH 17 Rev 1/2001

Terrace

45 Tarm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIN

APR 1 3 2006

WONSOCK

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

			For State Registrar	State of Maryland /			f Health a of Death			iene	5	3871
	Physici		1. Decedent's Name (First, Middle, Last) Bryton Skylar RUDI	STLL					2. Date of Dear		rear	3. Time of Death 20:02 PM
	/Medic Examin		4a. Facility Name (If not institution, give st		//	4b. City, Tow	m, or Location	of Death	11/2000	4c. County of	Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t	A (birthday)	If Under 1 Yo			8. Date of Birth	Balti		ce (State or Foreign
	Director		None	M 2□F	Yrs.	Months Da	ays Hours	33	(Month, Day, April 1	4 2006		yland
	yland sow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation					10d.	I. Inside City Limits
	e Mar	ctor	Maryland Washingt	on Ha	agers	stown						1 ☐ Yes 2√ No
	with th	Directo	10e. Street and Number			10f. Zip Cod			1	0g. Citizen of Wh	at Country	/?
	death	nera	13608 Rockcliff Dr 11. Marital Status	IVE 2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent	742 of Hispanic Ori	igin? (Spe	ecify Yes or No-		- American	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 ehow the Madical Examinar must be notified at	by Funeral	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give		Tes, specily €	Cuban, Mexicar No <i>Specify:</i>		nican, etc.)	Specify:	White, etc	
Maryland 21215-0036	2 hour atural'	ted b	15. Decedent's Educ	Year or Dates:	Sa. Deced	lent's Usual Oc	cupation			16b. Kind of Busi	White iness/Indus	
215	ithin 7. nan "n wed	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work do DO NOT use re	one during mos atired)	t of worki	ng			
d 2	filed w Hygier other th		None 17. Father's Name (First, Middle, Last)	None		Non		ar's Name	(First, Middle, I	None Maiden Sumame		
<u>lan</u>	should be nd Mental marked o	To Be	Terry Rudisill				A	shle	y D. Loi	ng		
Aary	C1 G 20 E2		19a. Informant's Name/Relationship (Typ							, City or Town, St		
	1 and Health tem 27 other ti		Ashley D. Long - M 20a. Method of Disposition			Rockc sition (Name on natory or other		100	The second second	town, Md 20c. Location - C		
Ē	Pages nent of t ant: If its ary or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 3 ☐ Other (Specify)				atory 4	/18/	06 1	Hagersto	wn, M	[aryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licenses	Manner						uneral H town, Md		740
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do	o not ente	er the mode of	dying, such as	cardiac	or respiratory arri	est,	In	pproximate nterval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	RESpiratory	FAI	lune					33	nset and Death
	Examiner			Due to (or as a consequence	e of):	Hulin	14				21	links Stan
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):	1 June 1	7					wks 5day
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	POR e of):						12	-hRS
8760,	cate be executed oblysician and the burial-transit	dical E	C _d .									
ထ	entifica ling ph e as th	Med	IF FEMALE:		_							
Вох	that the death certifics ed by the attending pt detached for use as t	by Physician/Me	in the past 12 months?	 c. If yes, outcome of pregnancy 1□Live birth 2□ Fetal dea 4□Pregnant at time of death 		Ectopic pregna				23d. Date Month		
P.O.	tt the d by the tached	hysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		, , , , , , , , , , , , , , , , , , , ,	,					
Ś	es gue		Part II. Other significant conditions cont	ributing to death but not resulting	jin the ur	nderlying cause	given in Part I		23e. Did tot	oacco use contrib es 2 🏳 No 3		cause of death?
Record	e taw requir has been si je 2 should	Completed							24a. Was a	sy pric	ere autopsy or to comp	y findings available
	icate h						_		oerforr 1 Yes 2	ned? dea	ath?	No.
Z Z	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Impatient 2 ER/0	Outpatien	t 3 DOA	Othor		n <i>(Check only on</i> me 5□ Reside	ence 6 □Other	(Specify)	
on of	ding Phy h. After thi funeral c	-	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of Injury	28c. l	Injury at Work? 1 □ Yes 2 □			ow injury occurred		
Division of Vital	I or Attending after death. Director: After I in by the fune.	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre			-	28f. Location (St City or Town	treet and Number n, State)	or Rural R	Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	edical Ce	(Check only 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination a	lge, death and/or inv	occurred at th	ne time, date ar ny opinion, dea	nd place, a	and due to the ca	ause(s) and manr ate and place, an	ner as state	ed. ne cause(s)
	To the h	Med	29b. Signature and title of certifier	and manner stated.			ense number			9d. Date signed (
	F 3 F 8		1 Seral	2 MD		RES	5-000		E-10	4/14/20	206	
	11 2		30. Name and address of person who con	npleted cause of death (Item 23a	a) (Type, I	Print)	11	1	6111	a d M	1001	and 21287
ک	H -O Sta	te	Jacqueline Basclice 31. Date filed (Month, Day, Year)	32. Registrar's Signature	14.4	volte	STREE	T_/	141+IM	URC, Ill	12411	and 2128/
	Registr	_	APR 18 20	06 Seem B.	19	oute						

				State of Ma		d / Departme			•		gible.	10070	
		•	1 - For State Registrar		,	Certifica			,	Reg. No.	Ub	13016	
	Physici	an	1. Decedent's Name (First, Middle, La	ist)					2. Date of De Month	eath Day	Year	3. Time of Death	
	/Medic Examin	al	Dayton Hunter RI 4a. Facility Name (If not institution, give	JDISILL re street and number)	_	4b. City	, Town, or	Location of D	April	4c. Co.	2006 unty of Death	1943 PM	_
			The Johns Hopk				timo	re			Ltimore		
	Funeral Director		None	Sex 7. Age 1X M 2□F	(In yrs. Ia	Yrs. If Under Months	or 1 Year Days		Hrs. 8. Date of Bi Min. (Month, O 18 April]	ay, Year)		place (State or Foreign ntry) 1and	1
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Location						I Od. Inside City Limits	-
	Mary -f sho	ģ	Maryland Washir	ngton	ц	agerstown						1 ☐ Yes 21 No	
	or 28s	Director	10e. Street and Number	igeon	114		ip Code			10g. Citizen	of What Cou	ntry?	
	ath w		13608 Rockcliff				21742				USA		
	Item Inerro	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces?		3. Was Dec	edent of His ecify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	0- 14.	Race - Ameri Black, White,		
036	ral', or	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes	2 X No	Specify:		Spe	ecify: Whi	te	
Maryland 21215-0036	within 72 hours after death with the Maryland ane. then "netural", or Iteme 23e or 28e-f show he Jigal Exeminer must be notified at	Completed	15. Decedent's E (Specify only highest gr			16a. Decedent's Us (Give kind of w life. DO NOT	ual Occupa ork done d	tion uring most of	working	16b. Kind o	of Business/In	dustry	
12	withir iene. then	dwo	Elementary/Secondary (0-12) None	College (1-4or 5+ None)		None	,		N.	lone		
pu	be filed ital Hygi d other event, I	BeC	17. Father's Name (First, Middle, Las		\			18. Mother's	Name (First, Middle				
ylaı	should bind Ment	To	Terry Rudisill						D. Long				
Mar	d 2 sho		19a. Informant's Name/Relationship			range again (a)			r Rural Route Numb				
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene the filem 27 is marked other then "netural", or Iteme 23e or 28e-f show other traumatic event, I'm Medical Evander mantke colifical at		Ashley D. Long - 20a. Method of Disposition		20b. Pl	ace of Disposition (Nametery, crematory or	ame of		ve, Hager		on - City or T		-
E	Pages nent of int: If it		1 ☐ Burial 2X Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci		i	erstown Cr		! !	18/06	Hager	stown.	Maryland	
Baltimore,	permit. Pages Dep rtment of Important: If i any injury or		21. Signature of Funeral Service Lice	nsee	**	22. Name a	and Addres	s of Facility	Minnich H	uneral	Home		
	ŭ D ≟ e Ol		23a. Part1. Enter the disease, or con	polications that caused t	he death				vd. Hage		, Md.	21740 Approximate	
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line	. J	. Co . E	A L	, such as car	diac or respiratory a	111631,		Interval Between Onset and Death	
	Prrysician /Medical		disease or condition resulting in death)	aDue to (or sa	consequ	ence of):	niu	O .				48 minutes	
	Examiner		Sequentially list conditions,	b. Extre	me	Premat	urit	Y			3	llow ks 5d	ay
	nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequ	ence of).		24			1	llucks 5d	ľ
Ć,	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequ	ence of):					1	2 Mours	
3760,	# × •	cai		d									
x 68	leath certificat attending phy I for use as the	/Med	IF FEMALE:	23c. If yes, outcome of	f prognar	nev				7.7		-00	
Вох	death c	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □ Live birth 2 4 □ Pregnant at ti	Fetal	death 3 Ectopic				230.	Date of deliv Month	ery Day Year	
P.O.	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown									-
	es De	by	Part II. Dther significant conditions	contributing to death but	not resu	Iting in the underlying	cause give	n in Part I.		tobacco use d Yes 2 N		he cause of death? Dably 4 □Unknown	,
Vital Records,	w requir been si should	Completed										opsy findings available	
Rec	The lav	ldmo							auto	psy ormed?	prior to co death?	impletion of cause of	,
ital		0	25. Was case referred to medical	83				26. Place of	Death (Check only	2 □ No on <i>e</i>)	1 🗆 Yes	2/2 No	
of <	y S	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient		R/Outpatient 3 🗆 🗆		4 1401311	ng Home 5 ☐ Res			(y)	
o uc		ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury M	28c, Injury Work	at ? /es 2 □ No	28d. Describe	how injury oc	curred		
Division	deat ctor: y the	fical	2 Accident investigation 3 Suicide 6 Could not a determined	28e. Place of Injur	y - At ho	me, farm, street, facto		2	28f. Location	Street and N	umber or Run	al Route Number,	-
Ö	tal or A s after el Direc ed in by	Certification:	4 Homicide determined	building, etc.	(Specify)			City or To	wn, State)			
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying P (Check only one) Medical Exa	hysician: To the best of miner: On the basis of and manner state	examinati	viedge, death occurre ion and/or investigation	d at the tim on, in my op	e, date and p inion, death o	place, and due to the coccurred at the time	cause(s) and date and pla	manner as s ce, and due t	stated. o the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier			2	9c. License	number		29d. Date si	gned (Month,	Day, Year)	
			C/Strank			(RES	-000		4/14	106		
	H-0			Baselice	ath (Item	23a) (Type, Print)	nifo	S+ , R	altimore	MD	2179	7	
	Sta	ate	31. Date filed (Month, Day, Year)		's Signat			11,1	LIMICIE	110	6140	 	_
i e	Registi	rar	APR 162	100 la seu	- 10	. Sparks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e, f per gs g860 10-6-06 vt. State of Maryland / Department of Health and Mental Hygiene amenmd items 10a-c per gs g860:10-20-06 vt. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** A^{M} VIOLA **JENKINS** STRANGE 04 12 06 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3222 GUILFORD DR. WALDORF MD. CHARLES If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 200 F 51 07 - 19 - 54Director 178-44-4957 NEWYORK NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Md. PA. Philadelphia 1 XYes 2 No CHARLES Director WALDORF 10g. Citizen of What Country? 10e. Street and Number 5751 N. 12th St. 10f. Zin Code 19141 3222 GUILFORD 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black Š 3 Widowed XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Private Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental **JENKINS** SAMUEL TDA KEITT 19a. Informant's Name/Relationship (Type, Print) Nephew -19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l 3222 GUILFORD DR. WALDORF Md. 20602 STOUTAMIRE CLAUDIE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department o importent: If any injury or once. = 5 4-17-06 PHILADELPHIA PA. CHELTON Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee REESE PROFESSIONAL F.S. nw. WASHINGTON D.C20010 3605 14th st. 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinana Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): attending physicien for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Phknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 (250) 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 10 2 this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After To the Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 T Homicide within 24 hours a To the Funeral I completely filled LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 112 Louis

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Box 68760,

Ö

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Division of Vital Records,

20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

APR 1 8 2006

31. Date filed (Month, Day, Year)

03

2. Registrar's Signature.

			1 - For State Registrar	State of Ma	ryland		artment of tificate o			F	Reg. Nő.	A transport	13874
	Dhysiai		1. Decedent's Name (First, Middle, Last,)						Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medic		STEVEN		TAMBA	CH				April		006	2:25 A M
	Examin	er	4a. Facility Name (If not institution, give	street and number)			,	n, or Location of	f Death			nty of Death	
Cust .			Frederick Memoria		(In yrs. las	st hirthday)	Frede		24 Hrs.	8. Date of Birt		deric	k hplace (State or Foreign
*	Funeral Director		5. Social Security Number 6. Se	X 7. Age	57	Yrs.	Months Day		Min.	Jan. 8	, Year)	Cor	ington D.C.
			Usual Residence of Decedent		<i></i>					oun o	, 1717	110011	
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	a-fel	ctor	Maryland Frederi	Lck	Мо	unt A	iry				·		1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number				10f. Zip Cod	е			10g. Citizen o	of What Cor	untry?
	23a	rai	13880 Foggy Botto					771			U.S		
	t dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		. 13.	Was Decedent of Yes, specify C	of Hispanic Orig Juban, Mexican	gin? (Spe , Puerto F	city Yes or No- Rican, etc.)	14. R	ace - Amei lack, White	rican Indian, e, etc.
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	0		1 ☐ Yes 2 ½ 1	No Specify:			Spe	city: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f ehow I.a M.cileil Exeminer mual be ricilliad al	edt	15. Decedent's Edu			16a. Dece	dent's Usual Oc	cupation			16b. Kind of	Business/	Industry
5	in 72	Completed	(Specify only highest grad	de completed)		(Give	kind of work do DO NOT use re	ne during most	of workir	ng			
7	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5-	*)	Owne	r/Opera	tor/Med	chani	.c	Auto	Repa	ir
	othe othe	Be C	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Sum	ame)	
Maryland	uld be Aenta rked ric ev	ToE	Gerald W. Sta	ambach					cjori		nroe		
ary	and halls ma		19a. Informant's Name/Relationship (T)										Zip Code) 21771
	and and n 27		Barbara Ann Stamb	ach - Wif			0 Foggy						
ore	ges 1 I of H If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	Removal from State			sition (Name of natory or other			ate	20c. Locatio	•	
Ë	tant:		4 Donation 5 Other (Specify,		Meti					/18/06	Alexan	dria,	, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itama 23e or 28e-f ehow emportant: If Item 27 is marked other than "natural", or Itama 23e or 28e-f ehow emportant: If Item Madical Exact Instrument be rediffied at once.		21. Sign true of Fundral Service Licens	William	w	Mo	Name and Ado 1eswort 5401 Ric	th-Will ige Roa	iams d. D	amascus	, Mary	1 Hom	20872
		i I	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ine cause on each lin	the death. e.	Do not ent	er the mode of	dying, such as	cardiac o	r respiratory ai	rest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in dealin)	Due to (or as a									
1 49%		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. PNS of Due to (or as a									
	ted nsit	를	cause. Enter Underlying Cause (Disease or injury			,							
	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	conseque	ence of):					· · · · · ·		
760,	es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	cail		d									
89	tificat ig phy as th										-		
Box	h cert endin	N.	23b. Was decedent pregnant	23c. If yes, outcome of]Ectopic pregna	ancy				Date of deli	
<u>m</u>	The law requires that the death certifice ate has been signed by the attending phage 2 should be detached for use as It	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify					Month	Day Year
о. О.	at the I by the	Phy	9 Unknown							200 Did 4			the cause of death?
	res th igned be d	by	Part II. Other significant conditions co			-	nderlying cause ANCE			230. Did (es 2 🗆 No		obably 4 Unknown
orc	v require been się should t	Completed	10214314	10 6	070 3		410 621						
ec	e law has b	nple								24a. Was		b. Were au prior to d death?	itopsy findings available completion of cause of
<u> </u>										1 ☐ Yes		1 ☐ Yes	e DINO
Vital Records,	Physician: The lithis certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:				Othor	-	(Check only o			
	<u>ਦ</u> ਦੁ ਲ	- To	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	v 2	:R/Outpatier 28b. Time o	11 30 000	njury at Work?		ne 5 Residente la			cify)
Division of	Attending ir death.	ţ.	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year)	Injury		Work? 1 ∐ Yes 2 ∐ i	No				
/isi	dea ctor / the	fica	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At hon	ne, farm, st	reet, factory, off	ice	1	28f. Location (Street and Nu	mber or Ru	ural Route Number,
	al or	Certification:	4 Homicide	building, etc	:. (Брөспу)					City or Tox	vii, State)		
	To the Hospital or Attenwihin 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Cenifier Land Centifying Phy (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination	rledge, deat on and/or in	h occurred at the vestigation, in r	e time, date an ny opinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) and date and plac	manner as e, and due	s stated. e to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	_				ense number	<i>a</i> .		29d. Date sig		
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	5	and the second second	30. Name and address of person who o				Print) Street	Frede	rick	. Marv1	and 2	1701	
100	Sta Regist	ate	I.alit M. Verma 31. Date filed (Month, Day, Year) APR 1	32. Regis	ar's Signatu	Jre #	Sperk	, 11000		,			
	negist	ıaı					-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month April 16, 2006 Year **Physician** MERNA LOUISE SHAW 12:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland, Farms Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month. Day, Year) | 9. Birthplace (State or Foreign (Month. Day, Year) | 1926 | New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 257F 79 156-20-0336 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f show iner must be notified at 1√Yes 2□No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7407 Willow Road 21701 U.S.A. Be Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Amed Forces: 1 □Yes 2♠No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within ; h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) AT&T Chief Operator Mgr. T&TA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oswald Horsch Frieda Klett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traum George W. Shaw, Jr. / Son 9410 Erin Avenue, Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glade Cemetery 4/19/06 Walkersville, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee CONFIRT E. DAILEY & SON FUNERAL HOMES, P.A. NORTH MARKET ST., FREDERICK, MD 21701

Approximent on a entering mode of dying, such as cardiac or respiratory arrest,

Approximaterial B 23a. Part Ent is the disea of complications by a used the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alz heimers DIJCEJC **Physician** Tyenrs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or it pay that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 ANO of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 Z No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

tha Hospital or Attending

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lerner

15 East Frederick Street, Walkersville, Maryland 21793 Michael Lerner, MD

29c. License number

D41619

29d. Date signed (Month, Day, Year)

April 17, 2006

31. Date filed (Month, Day, Year) APR 1,8 2006

29b. Signature and title of certifier

32. Regarar's Signature

M.D

		1 - For State Registrar	State of Man				lealth an Death		Reg. No	HHID	138	76
Physici	ian	Decedent's Name (First, Middle, Last) MIT DDED	ONEIDA	CDECUM				2. Date of D	Da		3. Time of	
/Medi		MILDRED 4a. Facility Name (If not institution, give s		SPECHT	4h Cit	v Town o	r Location of D	April	15,	2006 County of Deat	2:55	A M
Examir	ıer	Frederick Memoria				ederi		-batti		rederic		
Funeral		Social Security Number 6. Sex	7. Age (//	n yrs. last birthday) If Unc	ler 1 Year	If Under 24 I	Hrs. 8. Date of Bi			nolano (Stato e	or Foreign
Director		217-48-0892	M 20XF 7	5 Yrs.	Month	s Days	Hours A	Min. 8. Date of Bi	ay, 7 ear)	1931 °°	MD	
pu *		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	onation						10d. Inside C	
f eho	ō	MD Freder				etowr	1					2 V No
the A	ect	10e. Street and Number				ip Code			10a Ci	tizen of What Co		
3a or	٥	9203 Baltimore	National	Pike	101. 1	217	769		rog. Of	USA	unitry:	
be filed within 72 hours after death with the Maryland nial Hygiene. ad other then "natural", or items 23s or 28s-f ehow event, the Madical Exam and natural be malified at	Funeral Director	·····	12. Was Decedent Eve		Was Dec			? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ame		
after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 Tes 2 No			_		uerto Rican, etc.)		Black, White		
ours LEE	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 103	21 7 140	Specify:			Specify:Whi	te	
ed within 72 hours afi giene. er then "natural", or " the Medical Exem	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deci	e kind of	vork done	ation during most of f)	working	16b. K	ind of Business/	ndustry	
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Hygi ther	Ö	17. Father's Name (First, Middle, Last)		110	usei	reepe		Name (First, Middle	, Maider			
should be nd Mental marked o	To Be	George Leather	cman				0ne	ida Har	shma	an		
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.	-	19a. Informant's Name/Relationship (Ty)		19b. Mai	ing Addre	ss (Street	and Number of	r Rural Route Numb	er, City	or Town, State, Z	ip Code)	
permit. Pages 1 and 2 Department of Health a mportant: If Item 27 is nny Injury or other tra		Robert A. Spech	ıt (Son)	4 De	fens	se Ct	:., He	dgesvil	le,	WVA 25	427	
of He of Herr		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ R		20b. Place of Disp cemetery, cre	matory of	other place	(8)	Date		ocation - City or		
Pag ment ant: I		4 Donation 5 Other (Specify)	emoval from State	Harmon	у С	emete	ery 4/	18/06	Мує	ersvill	e, MD	
srmit. Spartr Sport Ny Inf		21 Signature of Fundral Service Cense	99	2	Doma	and Addre	of Famility	mpson F	unei	al Hom	ie	
20 E # 9	1	mad Ing	1		31 I	E. Ma	ain St	., Midd	leto	own, MD	2176	9
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/Medical		resulting in death)	Due to (or as a co	onsequence of):	nov	(17					2 da	YS
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The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p							23d. Date of deli	varv	
death e atte	cia	in the past 12 months?	1□Live birth 2□ 4□Pregnant at tim		□Ectopic □ Other (:	pregnancy specify)			1	Month	,	Year
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he law requires tha e has been signed t age 2 should be det	ру Р	Part II. Other significant conditions con	4.4	=	underlying	cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of	death?
w require been sig should b		Diabeta 1	Mellitu Ty	pe 2				_ 10	Yes 2	□No 3□Pro	obably 4 🗍	Unknown
law ra as be 2 sh	Completed							24a. Was		24b. Were au	topsy findings ompletion of a	available
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ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						Death Check only	one			
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after Direct	ertif	4 Homicide determined	28e. Place of Injury building, etc. (S	Specify)	ireet, racto	огу, опісе		City or To		nd Number or Ru e)	rai moute Nun	100r,
To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director.	Medical Co	29a. Certifier (Check unity one) 1 ★ Certifying Physical Examirons)	sician: To the best of m	amination and/or is	th occurre	d at the tim	ne, date and pl pinion, death o	lace, and due to the occurred at the time	cause(s) and manner as d place, and due	stated. to the cause(s	s)
To the To the Complet	Mec	29b. Signature and title of certifier	and manner stated	-	2	9c. License	e number		29d. Da	te signed (Monti	, Day, Year)	
FIFT		21/.0.	MD			_		7		4/17/	2	
(6)		30. Name and address of person who co	impleted cause of death	(Item 23a) (Type	Print)	ע	0005	/		11:110	16	
		1 V in land	() (O	ALL LITH		UE	Bin	7 unswice	ć	MD 2	17/6	
Sta	ite	31. Date filed (Month, Day, Year)	32. Pagistrar's	Signature	A . A	1.		-inj will		- 4- 04-	0 0 0	
Regist		APR 1.8 20	306	JJ A	AND AS	ممت						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 14, 2006 **Physician** Year рМ Carolyn Stover 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 17, 1911 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗗 F 577-01-2555 94 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at any once. 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 3110 Gracefield Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status M☐Yes 2☐No If Yes, Give 1943-45 Year of Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify.White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Verizon Representative Communications 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daniel I. Stover Carrie Brubaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Lindell Street, Wheaton, MD 20902 John D. Stover/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 19, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2006 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 general. 23a. Part T. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sersis /Medical Due to (or as a consequence of): Examiner Perforated Colon Sequentially list conditions, if any leading 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Diverticular Abcess The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 □ No 3 ☐ Probably 4 ☐Unknown funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an hes autopsy performed? Yes 2 \times No certificate 1 Yes 2 No 1☐ Yes Be 25. Was case referred to medical 26. Place of Death | Check only one | examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ettending 1 Natural 5 Pending Injury 1 Yes 2 No death investigation 2 Accident the within 24 hours effer death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in th 4 - Homicide Hospital or 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23649 April 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3119 John Styckey , M. . D Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) APR 18 Registrar's Signature 2006 Registrar

Maryland 21215-0036

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Evan James Sh	utt	1- For State Registrar	State of Mary	land / Dep					20	06 1387		
Physici		Decedent's Name (First,	Middle Last)					2. Date of Dea	eg. No	3. Time of Death		
Medical Exami	iner	Evan Jar 4a. Facility Name (if not ins	nes Shutt					April 13, 2		1300 nrs		
9		Calvert Memorial		number)		4b. City, Town, o		eath	4c. County o	f Death		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Ye		Hrs. 8 Date of Bi		Birthplace (State or		
Director		212-75-8845	1 X M 2 F		Yı	Months Da	ays Hours	Min.	3, 2006	Foreign Country) MD		
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1 F. E.				10c. Cit	y, Town or Loca					10d Inside City Limit		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Reath and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, the Medical Examiner must be notified at once.	Director	MD (10e. Street and Number	Calvert			Sunder			On Citing of Mile	1 Yes 2 XN		
the Mi a or 2)	Dire	5760 Highla	and Lane			206] '	Og Citizen of What USA	at Country?		
with ms 23 be no	Funeral	11. Marital Status	12. Was D	ecedent Ever in I		as Decedent of H	lispanic Origin?	(Specify Yes or No	ecify Yes or No-			
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rs afte ural", miner	by	3 Widowed 4 15. Decedent's Education	Divorced If Yes, Give Y		1_	Yes 2 X N			Specify:	white		
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5-0036 illed within 77 Hygiene. I other than the Medical	mpl	0				none			none			
15-0 iled w Hygie if othe		17. Father's Name (First, M	ddle, Last)				18.Mother's Na	ime (First, Middle, I	irst, Middle, Maiden Surname)			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Dey arment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injery or other traumatic event, the Medical Examiner	o Be	Lester Ch	arles Sh	utt, :	Jr.		Ang	el Mari	Marie Buete ural Route Number, City or Town, State, 2			
MD and 2 show	2	Lester C. S		or	1							
e, N I and Health Titem		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of ce	emetery,	Date	Sunderland, MD 20689 Date 20c. Location - City or Town, S			
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Baltimore, permit Pages Lar Department of Hee Important: If the njvry or other tr	1	21. Sign lure of Funeral Ser	vice Licensee	AUCTIL J S	22.	Name and Addres	s of Facility	<u>-19-2006</u>	Dunkir	K, MD		
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To To	ğ-	29b. Signature and title of ce	and manner	stated		29c. Licens						
		aus		29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 14, 2006								
	-	30. Name and address of per	son who completed cau	se of death (Item	23a)							
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
Sta Registr	ite	31. Date filed (Month Pay Ye	ar) 1 2005 32. R	strar's Signatu	ıre							

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	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			m, or Location of Dea		4c. County of	
	Funeral Director		5/9-26-05//		(In yrs. last birt	hday) If Under 1 Y	oma Park ear If Under 24 Hr ays Hours Mir	n. (Month, D.		gomery 9. Birthplace (State or Foreign Country) Wash., D.C.
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0000	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelin and Membal byglene. If Heelin and Membal byglene "natural", or Iteme 23a or 28a-f show other traumatic event, the Medical Examinar mant be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ፟፟ Midowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give Year or Dates: 1	。 946–47	1 ☐ Yes 2 [X]		erro Hican, etc.)	Specify:	white, etc. white
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<u>a</u>	and lama	Ì	19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing Address (Str	reet and Number or F	Rural Route Numb	er, City or Town, S	State, Zip Code)
_	l and i		Susan S. Neely,	daughter	27	7042 Thoma	s Edward 1			
5	t of H If ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemeter	Disposition (Name o y, crematory or other		Date	20c. Location - (City or Town, State
Dallino	tmen tant:		4 ☐ Donation 5 ☐ Other (Specify		Washin	gton Nati		-17-06	Suitlar	nd, MD
מ	permit. Pages 1 and Department of Heelt Important: If item 2 eny Injury or other anges.		21. Signature of Funeral Service Licen	See Circum	gas.	22. Name and Ad Rausch		ome. P.A	. Owings	s, MD 20736
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	/Medical Examiner		resulting in death)	Due to (or as a	conseque ce c	LURE				
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5	ath. r: After se funera	ation:	27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day			njury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe	how injury occurre	d
	el or Atto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.		m, street, factory, off	ice	28f. Location (City or To		r or Rural Route Number,
	Hospit 24 hours Funere etely fille	edicai (29a. Certifier 1 Sertifying Phyone (Check only one) 2 Medical Example 1	ysician: To the best o liner: On the basis of and manner stat	examination and	death occurred at the	e time, date and place ny opinion, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To th Within To th	Me	29b. Signature and title of Certifier			29c. Lic	ense number		29d. Date signed	(Month, Day, Year)
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ı	10+1		30. Name and address of person who of 7600 CARRIES 31. Date filed (Month, Day, Year) APR 1 4 2005	completed cause of de	ath (Item 23a) (Type, Print) MAR	PARCE	(A)	209	3-06
	Sta	te	31. Date filed (Month, Day, Year) APR 1 4 2005	32. Registra	's Signature	Pi)	, , -	, 41)	- //	
	Registra	all T	11 1 4 2003	PARTITION P	100					

Stotler, Robert

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Robert P. Stotler 08, 2006 03:55 A^M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Lion's Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 30-Jul-1916 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**™**M 2□F Months Days Hours Min 89 Pennsylvania Director 167-07-6103 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event. If a Medical Experiment must be notified at 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Cumberland Director Maryland Allegany 10e. Street and Number 112 Porter Street 10f. Zip Code 10g. Citizen of What Country? 21502-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No WWI Specify: ξ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) pharmacy owner/operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Stotler Mary Theresa Fallon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Porter Street Cumberland 21502 Doris Stotler Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 MCCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-Apr-2006 Cumberland Maryland Cumberland Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ohn K.K Durst Funeral Home, 57 Frost Ave, Frostburg, MD 21532 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician aw year /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): physician Physician/Medical atlending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2X No 24a. Was an page 2 has autopsy performed? Yes 25 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funaral Director: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatur and title of 29c. License number 29d. Date signed (Month, Day, Year) lew D46346 April 8, 2006 (INE) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Huma Shakil 625 Kent Avenue; Cumberland, Maryland 21502 31. Date filed (Month, Day, Year) 32. Registar's Signature State APR 1 1 2006 Registrar

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			1 - For State Registrar	State of Ma	aryland	-	artmen rtificat			nd M		Reg. No.	5	3881
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last, John Morrison SMI Aa. Facility Name (If not institution, give Reeder's Memorial	TH street and number)				Town, or	Location of		2. Date of De Month	Day		3. Time of Death 9:45A.M.M.
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	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Washing	;ton	10c. City,	Town or Lo	cation rstow	m					1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with th	Dire	10e. Street and Number 9908 Garis Shop Ro	ad			10f. Zip	Code 21740				10g. Citizen of W USA	hat Cour	ntry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show aumatic event, its Medical Examinar must be notified at	by Funeral Directo		12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		li li		dent of His		rin? (Spe , Puerto f	city Yes or Ne Rican, etc.)	o- 14. Race Black	- Amend k, White, whi	
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_	0 = 0 5	To Be Co	17. Father's Name (First, Middle, Last) R. Preston Smith								(First, Middle Lnia Mi	, Maiden Sumame		
e, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone.		19a. Informant's Name/Relationship (Ty Janet Smith - wife 20a. Method of Disposition		20h Ria		Gari	s Sh		l., F		own, City or Town, S	y1an	d 21740
E E	Pages lent of B nt: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Place 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cen	e Hill	natory or o	ther place		4/22		20c. Location - C	•	Maryland
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NAME: SMITH, JBaltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

06-02482 Richard Allan Sills Please Type or Print in Black Indelible Ink

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DHMH 17 Rev 1/2001 OCME 10/2003

1- For Amend Items 23 Table of Maryland Department of Leath and Mental Hygiene Certificate of Death

Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician OBERT TAYLOR APR 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MERCY MEDICAL CENTER TIMORE MD Under 1 Year | If Under 24 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11-19-1938 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 225-46-9356 VTRGTNTA 67 Yrs. Director Usual Residence of Decedent 10a State 10c. City. Town or Location 10h Counts 10d. Inside City Limits 28a-f show Exercine must be notified at MD PRINCE GEORGE OXON HILL 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1215 DEVONSHIRE DR. 20745 U.S.A. Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. other than "n College (1-4or 5+) Elementary/Secondary (0-12) 12TH PUBLIC WORKS GOVERNMENT 12 should be filed w h and Mental Hygier 7 ie marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HOWARD TAYLOR ANNABELLE POTTS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i 1215 DEVONSHIRE DR OXON HILL, MD 20745 GLORIA TAYLOR/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY 04-18-2006 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.3 JERKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 - D. N 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY **Physician** disease or condition resulting in death) /Medical CERTIFICATION AS OVED BY MEDICAL SYMMINER Due to (or as a consequence of): Examiner NEUMONIA Sequentially let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of) attending physicien a for use as the burial 68760 Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by vdrip = EGIA 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one, examiner? Hospital Inpatient 2 ER/Outpatient 3 DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျ ō 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation Natural Driver in auto/auto impact death. 2 Accident 12/23/2005 Unknown PM 1 ☐ Yes **2** No io To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Rt. Ci210, Fare) Washington, MD determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wholakia. MD D0063326 APR 12,06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, MERCY MEDICAL CENTER BALTIMORE MD KUSH . R. DHOLAKIA 31. Date filed (Month, Day, Year) State APR 1 9 2006 Registrar

			1 - For State Registrar	State of N	Marylar		artmen <i>rtificat</i>			nd M		iene eg. No.)06	onecours CA.	884
	Physici	an	Decedent's Name (First, Middle, L.	•							2. Date of Dea Month	th Day	Yea		ime of Death
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	Examir	ner	4a. Facility Name (If not institution, gi		r)		1		Location of				ounty of De		
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	Funeral Director			1□M 2 3 F	5		Months	Days	Hours	Min.	8. Date of Birth (Month, Day) Aug. 11	,195	53 F	Country)	State or Foreign
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	ath w	a	15749 Good H	T					905				S.A.		
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23e or 28e-f show enzy injury or other traumatic event, the Medical Examinant regardless mortified at onze.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yes 25 If Yes, Give Year or Dates	s?] No		Was Deced If Yes, spec 1 ☐ Yes		spanic Origi n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		. Race - An Black, Wh pecify:		
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פ	d oth	Be	17. Father's Name (First, Middle, Las						18. Mother	's Name	(First, Middle, M	Maiden Si	ımame)		
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Mar	12 sh h and 7 is n		19a. Informant's Name/Relationship		_	1					l Route Number	-			
Baltimore, Maryland 21215-0036	iges 1 and of Healt if Item 2		Peyton Taylor 20a. Method of Disposition 1 Burial 2 Cremation 3		20b. P	emetery, crei	natory or o	ne of ther place	9)	D		20c. Loca	tion - City o	or Town, Sta	ate
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			30. Name and address of person who				Print)								
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			1 - For State Registrar	State o	of Marylan	•	artment of		and M		iene	6	13885
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п	Director		216-30-1426	1 ∑ M 2□F	69	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, June 1,	1936	Mar	yland
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	or 24	Olre	10e. Street and Number				10f. Zip Code			1	0g. Citizen of	What Cou	ntry?
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	Medical	(Check only 2 Medicel one)	Exeminer: On the b	asis of examinatine ner stated.	tion and/or inv	estigation, in my	opinion, deat	th occurre	d at the time, da	ite and place,	and due to	o the cause(s)
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			1- State of Maryland / De Registrar		artment of H			giene () (5 13886
			Decedent's Name (First, Middle, Last)			-	2. Date of Dea	ath	3. Time of Death
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	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of De		4c. County of	
			Memorial Hospital		Cumber	Land		Allega	ny
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	with a or								at Country?
	ns 23	Funeral	11418 Valley Road, NE 11. Marital Status 12. Was Decedent Ever in U.S.	13 V		502	(Specify Yes or No-	USA 14 Bace -	American Indian,
•	fter d	핊	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	lf.	Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	Black,	White, etc.
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Maryland 21215-0036	C1 10 - 0						Rural Route Numbe		
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9	of H of H or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of D cometery,)ispos , crem	sition (Name of natory or other place	ое)	Date	20c. Location - Ci	ty or Town, State
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	ician Sertifi ector	Be	25. Was case referred to medical examiner?		100		eath (Check only on		
5	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2:	tlon: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Inju	ne of	28c. Injun Wor	4 🗆 140751119	Home 5 ☐ Reside	ence 6 Other (Specify)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	ı, stree			28f. Location (SI City or Town	treet and Number on, State)	or Rural Route Number,
,	he Hospit n 24 hours he Funera pletely fille	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, description on the desired examination and/of and manufactures.	death or inve	occurred at the tin	ne, date and pla pinion, death oc	ice, and due to the courred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
		ž	29b. Signature and till not chatritier		29c. License			9d. Date signed (A	Nonth, Day, Year)
	3		Chen Conto Mo		(1)	20182	.16 A	pril 18	? , 2006
			30. Name and address of person who completed cause of death (Item 23a) (Tyl	/pe, P	rint)			-	
_	TRS		Smith, Steven R., M.D., 600 Memoria	a1	Avenue,	Cumber1	and, MD 2	1502	
	Sta Registra		31. Date filed (Month, Day, Year) APR 2 0 2006 32. Registrar's Signature		book				

			1- For State Registrar	State of Ma		d / Depa		t of H	ealth a				06	13887
	Physici	an	Decedent's Name (First, Middle, Last,								2. Date of Dea Month		Year	3. Time of Death
1	/Medi		ADELAIDA TORRI								April	14	2006	12:40A M
	Examir	ner	4a. Facility Name (If not institution, give Montgomery Hospic		Jourga			Town, or kvil	Location o	of Death			ounty of Death	
	<u> </u>		5. Social Security Number 6. Sec			st birthday)	If Under		If Under :	24 Hrs.	8 Date of Birth		ontgome	
	Funeral Director			M 21X1F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day) Oct. 23,	1922	Peru	ace (State or Foreign try) L
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28e-f show is Madical Exerciter marker rediffied at		10a. State 10b. County		10c. City,	Town or Lo	cation						10	Od. Inside City Limits
	a-f si	ctor	Maryland Montgom	ery	Ro	ckvil.	le							1 ☑ Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizer	n of What Count	try?
	ath w	rall	15 Forest Landing	Court			20	850				U.S	.A.	
	tems rer m	nne		Was Decedent E Armed Forces?		13.	Was Deced f Yes, spec	ent of His	spanic Orig	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14.	Race - America Black, White, 6	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo		1⊠ Yes 2	2□ No	Specify:	Peru	vian	Sp	pecify: Whit	e
21215-0036	72 hours after death with the Marylan "natural", or Items 23a or 28a-f show idleal Exercities mast ke molified at	ed	15. Decedent's Edu			16a. Deced	dent's Usua	I Occupa	tion			16h Kind	of Business/Ind	lista
212	I within 72 ho ilene. r then "netu ine Medicel	plet	(Specify only highest grade Elementary/Secondary (0-12)	e completed)	.)	(Give	kind of wor DO NOT us	k done d	uring most	of worki	ng	TOO. TUITG	01 5451110534110	a stry
215		Completed	5th	College (1-4or 5	+)	F	lousew	rife				Do	mestic	
p	be filed ital Hygi id other event, I	Be C	17. Father's Name (First, Middle, Last)								(First, Middle, I	M aiden Su	mame)	
Va	should by	2	Celestino Gavidi	la					Eloi	sa	Ayala			
Maryland	C/ C = 6		19a. Informant's Name/Relationship (Ty								il Route Number	•		
	1 and Health em 27 ther tr		Nelly Alvarez/Dau	ghter	005 01-						-			and 20850
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☒ R	emoval from State		netery, cren		ie of her place)				tion - City or Tov	wn, State
Ë	permit. Pag Department Importent: I eny injury o		4 □Donation 5 □ Other (Specify)			Campo			1		/2006		, Peru	
Ba	Departing Departing Important in European		21. Signature of Funeral Service License	Perce	ti	HÎ 11	NES-R 800 N	INAI Iew H	DI FU Lampsl	JNER nire	AL HOME, Ave, Si	INC 1ver	Spring	, MD 20904
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heartfailure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	ncer		er the mode	of dying	, such as o	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	ıl Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a										
87	physi the t	dlcal		l										
P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal d	leath 3	Ectopic pre Other (spe					23d	. Date of deliver Month [y Day Year
	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions con	tributing to death bu	t not result	ing in the ur	nderlying ca	use givei	n in Part I.		23e. Did tob	acco use	contribute to the	cause of death?
rg	w require been sig										1 ☐ Ye	s 2 🔀 N	lo 3 ☐ Proba	bly 4 □Unknown
	The faw ite has b	Completed									24a. Was ar autops perform 1 Yes 2	y ned?	4b. Were autop prior to com death? 1 ☐ Yes 2	sy findings available pletion of cause of
Vital	ician: Th certificete ector, pag	Be	25. Was case referred to medical examiner?	ospital:				-		of Death	Check only one	9)		
of	iding Physician: th. After this certifice funeral director, p	lon: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	1 ☐ Inpatier 28a. Date of Injun (Month, Day	/ 2	R/Outpatien 8b. Time of Injury		c. Injury Work	at	2	ne 5 Reside 28d. Describe ho			Hospice
Division	Il or Attending after death. Director: After d in by the fune	flca	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At hom	e, farm, stre				-	28f. Location (Str	reet and N	umber or Rural	Route Number
ā	tal or s afte el Dir	l Certification:	4 Hornicide	building, etc.	(Specify)						City or Town	, State)		
	the Hospi hin 24 hour the Funer npietely fill	edical	29a. Certifier 1☒ Certifying Phys (Check only one) 2☐ Medical Examin	ner: On the best of and manner stat	examinatio	euge, death in and/or inv	occurred a estigation,	it the time in my opi	e, date and nion, death	n place, a	and due to the ca ad at the time, da	use(s) and ate and pla	d manner as sta ice, and due to t	ted. the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier				29c.	License	number		29	d. Date si	gned (Month, D	ay, Year)
}			NAZI		Wi	>		356	535		I	April	15, 20	06
	5		30. Name and address of person who con Joseph Kaplan, MI	, 6001 Mu				ad,	Rocky	vill	e, Maryl	and	20855	
*	Sta Registr	te ar	31. Date filed (Month Pay, Year) APR 1 7 20	06 32 egistra	r's Signatur		well.							

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Items 4a,b,c,26 per Dr. C. C. 1775 105/02/06 hb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Claybrooke Tannehill William | 9:20 Aм April 2006 /Medical Southern Maryland Hospital Center 12812 Country Lane Prince Georges
Charles 4b. City, Town, or Location of Death Examiner Clinton Waldorf If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ★M 2 ☐ F 85 Yrs. Director 720 14 5858 Sept. 8,1920 Virginia Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28e-f show trsumatic avent, the Medical Exeminer must be notified at Maryland 1 Yes 2 XNo Director Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other than "--- any injury or other traument. 1028 Broadview Road 20744 Be Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married toryes 2 □ No If Yes, Give 1 Year or Dates: white 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Inspector Natural Gas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Claybrooke Tannehill Sr. Virginia Chapman Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Bruce Tannehill 12812 Country Lane, Waldorf MD 20601-3340 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Cedar Grove Cemetery April 24,2006 1 Deurial 2 Cremation 3 Removal from State Bealeton, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 233 Broadview Ave Moser Funeral Home Inc. Warrenton VA 20186 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 4 CUTE MYOCARDIAL INFANCTION /Medical Due to (or as a consequence of): Examiner PERTENSION Sequentially list conditions, if any, loading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical he use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SHResidence 6 Other (Specify) 1 ☐ Yes 2 ☐No ၉ 1 Inpatient 21 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Malen ie o MD D 50689 04/18/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTHERN MARYLAND HOSPITAL CENTER
7503 SURRATTS ROAD CLINTON MP JOHTS AHIL MMAHAJAN mB 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

DHMH 17 Rev 1/2001

			1 - For State Registrar	Sta	ite of Ma	arylan			nt of H te of L		and N	/lental H		ene	6	138	89
	Dharia		1. Decedent's Name (First, Middle	, Last)								2. Date of				3. Time	of Death
	Physic /Medi		Bramina Linda	Umalas								April	1,	2006	Year	1:00	р
	Examir		4a. Facility Name (If not institution	, give street a	and number)			4b. City	, Town, or	Location of	of Death			4c. County	of Death		
			3939 Seaside C		202					Beac				C	alve	ert	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 28	7. Age		last birthday)	If Unde Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of (Month,	Birth Day,	Year)	9. Birth	place (State untry)	or Foreign
	Director		102–30–3453 Usual Residence of Decedent		X.	97	Yrs.					6/18/				Laty	
	show		10a. State 10b. County			10c. Cit	y, Town or Lo	cation								10d. Inside (City Limits
	Mary -fah	ρ	MD C	alvert				7	Touth	Beac	-la						s 2 🗆 No
	r 28a	Director	10e. Street and Number	arver c					p Code	Deac	211		100	g. Citizen of W	hat Cou	intry?	-
	ours after death with the Maryla al', or itema 23a or 28a-f shov Exa cilner cust be notified at	O E	3939 Seaside	Court :	± 202					207	11.4					Í	
	deat	Funeral	11. Marital Status	12. Wa	s Decedent E	ver in U.	S. 13.	Was Dece	dent of Hi			ecify Yes or Rican, etc.)	No-		- Amer	ican Indian,	
9	after or Ite		1 X Never Married 2 ☐ Marri	ed 1 🗆	ned Forces?]Yes 212]N es, Give	0	1	_			i, Puerto	Rican, etc.))		, White	, etc.	
8	72 hours af	d by	3 Widowed 4 Divorced	Yea	ar or Dates:			I LJ T es	2 <mark>X</mark> No	<i>ър</i> еспу:				Specify:	W	nite	
5	within 72 hours after death with the Maryland jiene. r than "natural", or Itema 23a or 28a-f show the Modical Exanither matter notified at	Completed	15. Decedent (Specify only highes	s Education t grade comp.	leted)		16a. Deced (Give	kind of we	ork done d	uring most	t of work	ing	16	6b. Kind of Bus	iness/li	ndustry	
12	withir ene. then	ш	Elementary/Secondary (0-12)		lege (1-4or 5-	+)	life. I		ise retired,			_	_	• •	_	_	
7			17. Father's Name (First, Middle,	4				Lib	raria		rto Name	- /First Adid		Library		Congr	ess
anc	a a a	Be	Aabram Umalas	.431/						18. Mothe	_)		
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S S	U 00 = 00	1 1	Marjorie Mastra													p Code)	
Baltimore, Maryland 21215-0036	Health tem 27 other tr	1 3	20a. Method of Disposition	110/610/	rrtend		lace of Dispo emetery, cren	alliu sition (Na	C AVE me of	nue,		th Res		MD 20		own. State	
OLL			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St	3 □Removal	I from State						/2 /2	006					
≣		. 1	21. Signature of Funeral Service I			CITE	sapeak	Name a	emate nd Addres	ory (4)	/3/2	006	E	Beltsvi	lle,	MD	
ã	permit. Departr Imports any Inj	0.0). Chilm	1	1			O Da	42C) D	, Ka	ymona-	-WOC	d F.H.	, P.	.A.	
-	.3 - 2 - 3		23a. Part1. Enter the disease, or	complications	that caused t	the death	n. Do not ente	er the mod	de of dying	such as	IKIT.	r respirator	ZU / v arres	154 t.		Approxima	te
	Physician		Immediate Cause (Final	only one caus	e on each line	e. Maria	triti	tra	, -			.,	,	-,		Interval Be Onset and	tween
	/Medical		disease or condition resulting in death)	a	" lax	141	V) - / L (_		
	Examiner			Ī	re hy	dra	TIN)									
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	outed id ansit	Examine	Cause (Disease or injury that initiated events														
ó	an ar rial-ti	EX	resulting in death) Last	D.	ue to (or as a	consequ	uence of):								_		
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9	n certifica anding pt use as ti	Med	IS SEMALE.	1			-						-				
Вох	eath certifi. attending I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If ye	s, outcome o Live birth 2	f pregnar		Ectopic p	reanancy					23d. Date	of deliv	ery	
	e dea	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 🗆	Pregnant at to			Other (se					_	Mont	h	Day	Year
0	that the de led by the a detached	Phy	9 Unknown														
	9 76 es	by	Part II. Other significant condition	s contributing	g to death but	t not resu	ilting in the un	derlying o	ause give	n in Part I.		23e. Di	id tobac	cco use contrit	ute to t	he cause of	death?
0.0	w requir been si shoutd	ted										1[☐ Yes	2 □ No 3	Prot	bably 4 🗹	Unknown
Records,	e law has b	Completed										24a. W	as an	24b. W	ere auto	opsy findings impletion of o	available
-		Co										pe 1 ☐ Yes	ntórme	d2 de	ath?	2 🗆 No	
Viita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?							26. Place	of Death	Check on	(ne)				
	Physician: r this certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital:	1 L Inpatient		ER/Outpatient			4 🗀 1901	sing Hor	me 5 Re	esidenc	e 6 Other	(Specii	fy)	
n N	ding Physician: h. After this certific funeral director,	lon:	27. Man ⊕r of Death 1 Natural 5 □ Pending		Date of Injury (Month, Day	Year)	28b. Time of Injury		28c. Injury Work			28d. Describ	e how	injury occurre	1		
<u>S</u>	Attending r death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could no	ot be	Dia			М		es 2 N							
Division of	I or Attendated after death Director:	Certification:	4 Homicide determin	ned 28e.	Place of Injur- building, etc.	y - At hor (Specify,	me, farm, stre	et, factor	y, office		1	28f. Location City or	n (Stree Town, S	et and Number State)	or Rura	al Route Num	nber,
	ospital hours uneral ly filled		29a. Certifier 1 Certifying	Physician 1	To the best of		ded ded										
	1 4 5 E	Medical	29a. Certifier 1 Certifying 2 Medical E	Adminier. On	the basis of e I manner state	xamınatı	viedge, death ion and/or inv	occurred estigation	at the time , in my opi	e, date and nion, death	l place, a h occurre	and due to the ed at the tim	ne caus e, date	se(s) and mani and place, an	ner as s d due to	itated. o the cause(s	s)
	To the within To the comple	Me	29b. Signature and little of certifier		THE TOTAL			290	. License	number			29d	. Date sig ed	Month	Day Year)	
	- s - á		MA	7/	nn				1) 37	1585	1		4	12/11	0		
			30. Name and address person w	ho complet	of day	ath /lto-	23a) /Turns 5	Print\					· ·	10100			
	24	1	Rafik Nash	1110	1004	5 1	23a) (Type, F	Cer	nter	- B1	12.	· Dus	JŁ.	VK, n	110	207	54
	Sta	te	31. Date filed (Month, Day, Year)		32. Registr	s Signati	ure	_	102	110		201	,	, //	11	del	9
	Registra		APR	0 4 201	05 > 6	ACUR.	, K	400	the s								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JOSE ROBERTO 15,200 6 VALLADARES /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**X**M 2□F Director 579-74-3724 70 **GUATÉMALA** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "netural", or items 23e or 28e-1 show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23e or 28e-f shov Examiner must be notified at Director 1 XYes 2 ☐ No MD. PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4105 CRITTENDEN ST. 20781 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: GUATEMALAN 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced WHITE other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 SECURITY GUARD LIFE INSURANCE CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JOSE VALLADARES** 2 MARTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARITA VALLADARES/WIFE 4105 CRITTENDEN ST., HYATTSVILLE, MD. 20781 éb 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Himportant: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND NAT'L. CEM. 4-20-2006 LAUREL, MD. 21. Signature of Funeral Service Zicensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A - Cham MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Friysician Arrhythmin resulting in death) /Medical Due to (or as consequence of) Examiner CARRITE Sequentially list conditions, any, backing to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Be Completed 24a. Wasan 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29b. Signature and title of celtifier 29c. License number 29d. Date signed (Month, Day, Year) 721260 4/15/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICCOMA 30ROLL (600 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 18 2006 Registrar

Ø.
, 68760,
P.O. Box
Records, I
of Vital
Division (

				Please 1	Type or Pri							ible.	
			For		State of Ma	aryland .	/ Depai	rtment of	Health and	Mental Hy	giene	25.0	10001
			1 - Stete Registrer				Cert	ificate of	Death		Reg. No.	0	13891
	Physici	an	Decedent's Name (First							2. Date of De	eath Day	Year	3. Time of Death
	/Media		Catherine		hitlock					HPY1	17 20	006	1:55A M
-3	Examir	ner	4a. Facility Name (If not in						or Location of Deat	th /	4c. County		
		450	Doctor's C 5. Social Security Number			a⊥ le (In yrs. last	highday	Lanh		B Date of B			George's
6,	Funeral Director		093-22-9404			77		Months Days			1928	9. Birth	place (State or Foreign Intry) York
-			Usual Residence of Deced							nug.	1 1 1 2 0	TAGAA	TOTA
	irylan how	_	10a. State 10b.	County		10c. City, T	own or Loca	ation					10d. Inside City Limits
	h the Maryland or 28a-f ehow	Director		ince G	eorge's		Bowie	9					1 Dorres 2 □ No
	vith th	Dire	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Cou	ntry?
	be filed within 72 hours after death with the Maryland hat Hygiene. Ad other then "naturel", or teme 23s or 28s-f ehow event, the Maulcal Examiner must be notified at	Funeral	1205 Pensi						716		USA		
	ler de Item	nue.	11. Marital Status		12. Was Decedent Armed Forces?		13. W	as Decedent of I Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	o- 14. Rad Bla	ce - Ameri ck, White,	can Indian, etc.
35	irs af	by F	1 Never Married 2		1 ☐ Yes 2 ☐X1 If Yes, Give Year or Dates:	NO	10	☐ Yes 2🂢 No	Specify:		Specif	^{y.} Whi	1+0
9500-61717	2 hou		15. De	ecedent's Edu	cation	1	6a. Decede	nt's Usual Occu	pation		16b. Kind of B		
	thin 7	Completed	(Specify only Elementary/Secondary (y highest grade (0-12)	e completed) College (1-4or 5	5+)	(Give ki life. DC	nd of work done O NDT use retire	during most of wo	rking			,
V	filed will Hygien Ather th	Con	9	``	3 ()		Mea	at Packe	er		Meat P	roces	ssing
_	0 = 0 >	Be	17. Father's Name (First, A						18. Mother's Na	me (First, Middle	, Maiden Suman	ne)	
yla	2 should be and Mental Is marked c	2	Joseph Whi					<u> </u>		ne Savaç			
Mar	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked eny Injury or other traumatic evance.		19a. Informant's Name/Re						and Number or Ru				Code)
a	Healt Healt Healt Her		Jack Whitlo 20a. Method of Disposition		ouse			Pensive	Lane B	owie, MI	20c. Location -		Outro State
Saltimor	ages ont of it: if it y or c		1 X Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O	nation 3 🗆 R	lemoval from State	ceme	etery, crema	tory or other pla					
	ortan		21. Signature of Funeral S			nary.		Name and Addre	Cem. 04				I, MD.
ă	Depa Impo eny Ir	9 0) er	4.00	You al	Q			rainHwy.	eall Fur Bowie		e 20715	
			23a. Part1. Enter the dise shock, or heart failure	ase, or compli	cations that caused	the death. D						20713	Approximate
F	hysician		Immediate Cause (Final disease or condition	o. List only of	10 04430 011 0401 111	Arry	+L.w.	1.5					Interval Between Onset and Death
4	/Medical		resulting in death)	•	Due to (or as	a consequence	ce of):	167					
, h.	Examiner		Sequentially list conditions	s. I b	o/	HYPRA	ter-0	100					
	D is	iner	if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	tė 🥒	Due to (or as	a consequenc	ce of):	1/	ï	6.			
	executed an and rial-transit	Examin	that initiated events resulting in death) Last	0	Due to (or as	a consequence	20 of):	Virs	cular	W15 200	7 <		
5	sician buria				,		.,.						
00	p phys	Physician/Medical											
۲ 2	nding use a	ZM	IF FEMALE: 23b. Was decedent pregna	ant 2	3c. If yes, outcome	of pregnancy					23d Dai	te of delive	arv
0	e atte	icia	in the past 12 months 1 ☐ Yes 2 ☐ No		1 Live birth 4 Pregnant at			ctopic pregnanc other (specify) _	y		Мо		Day Year
ָ ֭֭֓֞֝֞֝	by th	hys	9 Unknown		9□ Unknown								
ń	pe de	þ	Part II. Other significant co	onditions con	tributing to death bu	ut not resulting	g in the unde	erlying cause giv	ren in Part I.	23e. Did t	obacco use cont	ribute to th	ne cause of death?
Solds,	s uee s uee	Completed								101	/es 2□No	3 Prob	ably 4 🗆 Unknown
ט פ	has b	npie								24a. Was	an 24b. V	Nere auto	psy findings available mpletion of cause of
- i	cate ; pag	S		_						1 Yes	rmed?//	death?	2 12 No
	certif	Be	25. Was case referred to mexaminer?	100	ospital:			! 0#	26. Place of Dea				
5	rthis	- L	1 Yes 2 No		1 🗀 Inpatie		Outpatient o. Time of	3 DOA	er: 4 Nursing H		dence 6 Other		y)
5	th.	흔	1 ☑Natural 5 ☐ I	Pending investigation	28a. Date of Injur (Month, Day	(Year)	Injury	28c. Injur Wor	k? Yes 2 □ No	Edd. Describe	iow injury occurr	В	
	r dea ector by the	ifica	3 Suicide 6 0	Could not be determined	28e. Place of Inju	ıry - At home,	farm, stree			28f. Location (S	Street and Numb	er or Rura	I Route Number,
5 3	s afte	Certification:	4 Homicide	/	building, etc	:. (Specify)				City or Tov	vn, State)		
9	The interpret of which the properties. The law requires that the bean centificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai (29a. Certifier 12 Ce	ertifying Phys	icien: To the best of	of my knowled	ige, death o	ccurred at the tir	ne, date and place	, and due to the	cause(s) and ma	nner as st	ated.
4040	the F	Medi	one)		and manner sta	ted.	and/or myes	anganon, in my o	pinion, death occu	rred at the time,	date and place, a	and due to	o the cause(s)
1	Twit Co.	Σ	29b. Signature and title of o	certifier		/		29c. Licens	e number		29d. Date signed	(Month, I	Day, Year)
2	12	-		7	1 1.	1).		INDI	06054	5	4pril	17,2	2006
_	(5)		30. Name and address of p	person who cou	mpleted cause of de	eath (Item 23a	a) (Type, Pri	Stree	t Suit	351 1	allel	MN	2 arm
3.3	Sta	e	31. Date filed (Month, Day,	Year)	32 Registra	r's Signature	1611	-1100	SUIN	1001 6	-4010,	,,,,,	2010
	Registra		APR 1	9 2008	mpleted cause of de	1	Anna	(a)					

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artmer			d Men		iene	06	138	92
	Physic	ian	Decedent's Name (First, Middle, Last)							Date of Deat Month	h Day	Year	3. Time of	Death
	/Medi				WORLEY	Jr.				pril	14,	2006	4:29	A M
4	Examir	ner	4a. Facility Name (If not institution, give s		1	1		Location of D	eath			unty of Death		
		'spi	Frederick Memorial 5. Social Security Number 6. Sex		L e (In yrs. last birthday		eder:	LCK If Under 24 h	Hrs pr	ate of Birth	Fr	ederic		
	Funeral Director			M 2□F	55 Yrs.		Days		Vlin.	Month, Day,		0 Mar	place (State o ntry) yland	r Foreign
	anyland show		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside Cit	ty Limits
	B-f s	ctor	Maryland Frederic	k	Ijamsv:	ille							1 🗌 Yes	² √□ No
	ours after death with the Maryla ral', or Itama 23a or 28a-1 shov Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zi	p Code			10	0g. Citizer	of What Cou	ntry?	
	ath w	ra	2743 Loch Haven				2	L754				U.S.A	•	
	er de Itams	une		 Was Decedent Agned Forces? 1 A Yes 2 ☐ I 	Ever in U.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Origin? n, Mexican, Pu	? (Specify uerto Ricar	Yes or No- n, etc.)	14.	Race - Ameri Black, White,		
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Woivorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 🕅 No	Specify:			Sp	ecify: Whi		
Ş		ed	15. Decedent's Educ			dent's Usu	al Occupa	ation				of Business/In		
215	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(Give		ork done o	luring most of	working	1		ing and	,	
217	filed withi Hygiene. other then	ĕ	12	College (1-40) 3		er/Op	erato	or				itioni		
ם	m = 0 %	Be (17. Father's Name (First, Middle, Last)					18. Mother's i	Name (Fir					
<u>ya</u>		2	Fred H. Worley,	Sr.				Pauli	ine I	Ethe1	Bur	gess		
Maryland 21215-0036	and and and		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Addres	s (Street a	ind Number or	r Rural Roo	ute Number,	City or To	own, State, Zip	Code)	
	s 1 and 2 if Health item 27 i		Kimberlee Worley -	Daughter		Broad		Venic		alifor		90291		
Baltimore,	T of a		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	20b. Place of Dispo cemetery, cre	matory or o	other place		Date			ion - City or To		
Ë	t. Pa then tant:		4 □ Donation 5 □ Other (Specify)		Metropol:								_	nia
Bal	permit. Page Department: importent: the sny injury o		21. Signature of Funeral Service License	Sellia	m $\frac{1}{2}$	^{2. Name ar} 0 1esw 6401	nd Addres orth Ridge	s of Facility -Willia ≥ Road,	ams P. Dar	.A., F	uner , Ma	al Home	e 2087	72
П			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each in	10.				_				Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	5 Por	TANEOU	5 BI	ACTI	ERIAL	- 1/e	BITO	NITI	5	Onset and D)eath
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):									
		_	Sequentially list conditions, b.		a consequence of):	PSIS								
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence oi):									
	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consequence of):									
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89	ifficati g phy as the	edic	0.											
Box	leath certific attending pl	an/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome		7					23d	. Date of delive	ery	
œ.		sicia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant at]Ectopic pi] Other <i>(sp</i>						Month	Day Y	'ear
0	that the de ed by the a detached	Physicia	9 Unknown	9 Unknown			-							
Ś	es tha igned be del	þ	Part II. Other significant conditions cont	nbuting to death bu	it not resulting in the u	nderlying o	ause give	n in Part I.	2			contribute to the		eath?
Vital Record	The taw requires ate has been signi page 2 should be	Completed								1 Tes	s 2□N	o 3 🗍 Prob	ably 4-0	Inknown
Ö	law las bu	ple							_ 2	24a. Was an autopsy	2	4b. Were auto	psy findings a	available
		Son							1	perform	ed?	death? 1 ☐ Yes	2. No	1000 01
Vita Vita	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?				Tai	26. Place of D	Death (Che	ock only one)			
ot	N S D	ပ္	1 105 22 NO	spital:				4 140121110				Other (Specify	1)	
Ü	ing l	0	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury		Bc. Injury Work		28d. D	Describe hov	v injury od	curred		
<u>si</u>	death ctor: / the	Cat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of Inju	ry - At home, farm, str	M		es 2 □ No	28f. L	continu /Ct			15	
	after Direction by	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	eet, factory	, onice		261. L	city or Town,	State)	umber or Rura	I Houte Numb	er,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	cian: To the best of er: On the basis of and manner sta	of my knowledge, death examination and/or in	h occurred vestigation	at the time	e, date and pla inion, death oc	ace, and di ccurred at	ue to the cat the time, dat	use(s) and le and pla	d manner as st	ated.	
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner sta			. License					gned (Month,		
	+ 3 ± β		· Clux	n		- 1		479	151			14 - 7		
سب	HVIE	İ	30. Name and address of person who con	noleted cause of de	eath (Item 22a) /Tun-									
1	2.1.			MI HO	814 Tol	L"HO	use f	tue. F	RED	ERICK	, M	D 51.	701	
(5)	Sta	te	31. Date filed (Month, Day, Year)	32 Pagistra	r's Signature									
	Registr	- 0	APR 1 7 200	b Bear	UB A	sale)	•							

Please Type or Print in Black Indelible Ink Richard Jay Wenger State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day April 21, 2006 1905 hrs **Medical Examiner** Richard Jay Wenger 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Wheaton Regional Park If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Hours Director Country) Virginia JUL 26, 1949 56 220-54-2020 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits E S 1 X Yes 2 No 28a-f shov Rockville Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 20850 511 Lincoln Street United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Yes, Give Yea Yes 2 X No specify. Specify: White Widowed Divorced ⋧ "natural" 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 5+ Psychologist Mental Health ont of Health and Mental Hygiene.

It item 27 is marked other the other the other than 10 the 18 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Gloria Herman Jay Wenger Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 5609 North 23rd Street, Arlington, Virginia 22205 Bruce David Wenger / Brother 20b Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) Removal from State 1 Burial 2 X Cremation 3 Important: I Beltsville, Maryland Chesapeake Crematory 4/26/2006 Donation 5 Other Specify permit 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave. LL, Silver Spring, 21. Signature of Funeral Service Licenses M00956 fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Cardiomegaly with biventricular dilatation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical AMENDED item#23a,27,perME,g855,5/3/06 TI physician a the burial -X UNPENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records. 24b. Were autopsy findings available 24a. Was ar prior to completion of cause of autopsy certificate has death? performed' 1 🗸 Yes page ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Other₄ examiner? Hospital: 1 Inpatient DOA Nursing Home 5 Residence 6 Other Scene 2 ER/Outpatient 3 this 1 V Yes No After f 28a. Date of Injury (Month, Day, Year Manner of Oeath 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Director: d in by the f Pendina death. 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after 3 Could not be Suicide or Town, State) determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. April 22, 2006 MD 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Ana Rubio MD.

31. Date filed (Month, 1987)

Assistant Medical Examiner

2006

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year JOSEPH W. WOODS April 11, 2006 1:42Pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Bethesda Hospital Montgomery

9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□ F 121-01-9824A 107 Yrs Director West Indies 17,1898 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show the Medical Exeminer must be notified at ¥∰Yes 2 No Kensington Director Montgomery Md 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 238 3901 Hampden Street, U.S.A. 20895 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. "naturel", or iteme 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: West þ 3 ☐ Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Town Of Elementary/Secondary (0-12) College (1-4or 5+) Laborer Kensington 5th Grade in ury or other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be lift
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Alfred Woods

19a. Informant's Name/Relationship (Type Off) Attorney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #20878

113 Apple Blossom Way, Gaithersburg, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St Johns Cemetery 4/18/06 4 ☐ Donation 5 ☐ Other (Specify) Forest Glen, Md 21. Signature of Funeral Service bicervee 22. Name and Address of Facility Snowden Funeral Home P.A. 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rockville Md Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (oras a consequence of): **Physician** Heart Failure /Medical Examiner Artery Disease Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 DUnknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 🕉 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 70 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 Yes 2 No death. Director: / 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

t, 10

Baltimore, Maryland 21215-0036

Box 68760,

Records,

of Vital

Joseph

NOODS

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

MATTHEW 31. Date filed (Mon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

POFFENROTH MO
Year) 32 Pegistrar's Signature

9901

29c. License number

1)56652

29d. Date signed (Month, Day, Year)

April 12,2006

MEDICAL CENTER DR. ROCKVILLE, MD

			1 - For State Registrar	State of Mar		artment of H			giefie	13895
Т			1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	3. Time of Death
	Physici /Medic		Mark C. Witte	1s				Month April	Day Year 14, 2006	9:55 P M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De		4c. County of De	
			8309 Still Spring	Court		Bethesda			Montgomer	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 I		th 9. Bi	rthplace (State or Foreign
	Director		411-50-4578	X M 2□F	84 Yrs.	Months Days	Hours N	lin. (Month, Da July 14	y, Year)	ountry) .nnesota
	P .		Usual Residence of Decedent					10027	, 1,221 111	IIII DOLG
	inylar show	_	10a. State 10b. County	1	0c. City, Town or Lo	ecation				10d. Inside City Limits
	Ba-f	cto	Maryland Montgome	ry	Bethesda					1 X Yes 2 No
	or 24	S.	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
	23e	la l	8309 Still Spring	Court		20817			USA	
	r deg	ne ne	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin?	(Specify Yes or No- ierto Rican, etc.)	14. Race - Am Black, Wh	
9	or it	by Funeral Director	1 ☐ Never Married 2 ☐ Married	1 XYes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:	,,	Specify:	White
Š	urei'	d b	3 Widowed 4 Divorced	Year or Dates 192	15				Specify.	WILLCE
7	"net	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa kind of work done of	during most of	working	16b. Kind of Business	s/Industry
21215-0036	withir	п	Elementary/Secondary (0-12)	+ College (1-4or 5+)		DO NOT use retired r Executi	,	rice	Department	of Energy
7	filed within 72 hours after death with the Maryland Hygiene. Hygiene Insturel; or Items 23e or 28e-f show bit. The Medical Examinar must be invitited at	ပိ	17. Father's Name (First, Middle, Last)					Name (First, Middle,		02 =====87
au	ntal ned o	Be							maideri Surname)	
Maryland	should be and Mental s marked o umetic eve	To	Isaac L. Wittels 19a. Informant's Name/Relationship (T	ima (Print)	105 14-15		Bertha			
Z Z	d2s than 7 is r		Margaret Kearns Wi						or, City or Town, State, esda, Mary 1	, ,
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if tien 27 is marked other than "naturel; or items 23e or 28a-f show any injury or other treumetic event, the Medical Examination at the modified at once.		20a. Method of Disposition						20c. Location - City of	
aitimore,	Pages nent of P int: if it		1 ☐ Burial 2 🖾 Cremation 3 🖂	IOIIIOVAI II DIII SIAIO	20b. Place of Dispo cemetery, cren		1.0	prii		
	it. Partmer rtmer rtent njury		' 4 □ Donation 5 □ Other (Specify		Metropol:		-		Alexandria	
ä	permit. Departr import any inji		21. Signature of Funeral Service Licens	1	22					Home, Inc.
			Miderally	Je erald				ple Ave.,		Va. 22180
	Commun.		23a. Part1. Enter the disease, or come shock, or heart failure. List only of	ne cause on each line.						Approximate Interval Between Onset and Death
1	Trysician		Immediate Cause (Final disease or condition resulting in death)	a Acute	1401	MAAIN	17	MANCI.	hox	24hrs
	/Medical Examiner		rosaling in asaliny	Due to (or as a c	onsequence of):	1. 1	/ _	Disen	q.	-
		<u>_</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	SCHOO	116/1	MAI	11501	15e	SYRS
	led is	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence or).					1.05
6	and al-trai	хаг	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of):					
8/60,	icate be executed physician and s the burial-transit				,.					
		dical	•	d						
×	death certifi e attending p	/Me	IF FEMALE:	23c. If yes, outcome of p	pregnancy					
ZOZ	atter for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	o or death o	Other (specify)	-			
Ľ	The law requires that the the law been signed by thoage 2 should be detached.	'Ph	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
ecords,	signed b	d by	Sevence Del			, ,		1□Y		robably 4 Dunknown
Š	w requir been si should	Completed								
ב ה	The law cate has page 2 s	ш						24a. Was a autops perfor	sv prior to	utopsy findings available completion of cause of
										2 □ No
N I G	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otho		eath (Check only or		
=	hys his lidii	5	1 185 2 NO	1 L Inpatient	2 ER/Outpatient	3 DOA	4 Nursing		ence 6 Other (Spe	cify)
	ding h	on	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work	?	28d. Describe h	ow injury occurred	
	death death tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	On Olean of Initial	445 6 .		'es 2 □ No	100/1		
>	or A after Direc in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (S	PAT nome, farm, stre Specify)	et, factory, office		City or Town	treet and Number or Ri n, State)	ural Route Number,
-	To the Hospitel or Attending P within 24 hours after death. To the Funefal Director: After t completely filled in by the funera		29a Cartifier 17 Cartifular 2	giology To the beat of	v knowled			#		
:	Fun stely t	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	sician: To the best of m	amination and/or inv	occurred at the time estigation, in my opi	e, date and pla inion, death oc	ce, and due to the c curred at the time, d	ause(s) and manner as late and place, and due	s stated. a to the cause(s)
	ithin ;	Mec	29b. Signature and tyle of conflier	and manner stated	1	29c. License			9d. Date signed (Mont	
1			11111	I. sh	1 1.	200. 21061138), ~ C	10	Ju. Date Signed (MON)	ii, Day, Jeai)
	12		· / jury	TURKE	2 176		108	8	7///	106
			30. Name and address of per who c			-			/ /	0
			Gary Fisher, M.D. 31. Date filed (Month, Day, Year)	553 32 Registrar's		sin Ave.	#730, C	hevy Chas	e, Md. 208	15-4447
	Star Registra		ΔPR 1 8 20	06	H. Lou	when the				

DHMH 17 Rev 1/2001

		·	1 - For State Registrar	State of Maryla	-		nt of H te of L		and M	R	ag. No.	JUb	13896	
	Physici	an	Decedent's Name (First, Middle, Last)				į	2. Date of Deal	Day	Year	3. Time of Death			
	/Medic		Vivian L. Webber							04	14	2006	<u> </u>	
4	Examin	er	Sacreb Heart Hospital Cum Berland ALLEGA											
			5. Social Security Number 6. Se:		If Under 1 Year If Under 24 Hrs.									
ľ	Funeral Director		214-42-2370 1 M 2 F 69 Yrs.				Months Days Hours Min. (Month, L				h y, Year) 9. Birthplace (State or Foreign Country) MD			
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	cation							10d. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow eny finjury or other treumatic event, I're Medical Examinar must be notified at once.	5									1 ☐ Yes 2 No			
		ect	10e. Street and Number 10f. Zip Code						10g.			n of What Cou	intry?	
		ai Dir	497 Stringtown Hollow Road				15545				USA			
Maryland 21215-0036		by Funeral Director	11. Marital Status 1 □ Never Married 2 対 Married 3 □ Widowed 4 □ Divorced	12, Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S. 13. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:									
		Completed	15. Decedent's Education 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done					pation 16b during most of working				b. Kind of Business/Industry		
		d L	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) C College (1-4or 5+) C College (1-4or 5+)							Manufacturing				
		To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid											
			lastan I Hassaltanda											
			19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Addre	ss (Street a	and Numbe	r or Rura	l Route Number	, City or	Town, State, Z	ip Code)	
	and 2 Balth a n 27 is		James L. Webber,	' Husband	497	St	inate	own. Ho	olloi	v Rd., t	lundr	ian. PA	15545	
ē,	s 1 a f Hea item othe		20a. Method of Disposition	20b	Place of Dispo	sition (N	ame of		D			ation - City or T		
Baltimore,	Pages nent of I int: If its ary or o		1 Burial 2 □ Cremation 3 F 4 □ Donation 5 □ Other (Specify)		Porter (. 1		1	1_10.	-2006	ī	lyndman	DA.	
===	permit. Departm importa eny inju		21. Signature of Fineral Service Licens	90				s of Facility		-2000		granicy.	, 18	
Ö	Depa Depa impo eny i		* theat Cale	Rome	На	UW e.i	/ H. 2	Zeial	on Fi	ineral t	lome.	Hundm	an PA 15545	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de									Approximate Interval Between	
			Immediate Cause (Final disease or condition	A								Onset and Death		
1			resulting in death)	Due to (or as a consequence of): LEFT ATRIAL THROMBUS Due to (or as a consequence of):									26 (1441-3	
	Examiner		Sequentially list conditions										DAY5	
	ים פ	Examiner	sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										VEHRS	
	ecute and trans	саш	that initiated events resulting in death) Last		BRILLATION					96770				
90,	cien a	Ē	Tooling in doubly and	Due to (or as a conse	equence or):									
68760,	ificate be executed g physicien and as the burial-transit	edicai		i										
9 ×		Me	IF FEMALE:	22a If you guteame of granges										
Box		Physician/M	in the past 12 months?				Ectopic pregnancy					23d. Date of delivery Month Day Year		
o.		ysic	1 ☐ Yes 2 15 No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)											
ds, P.	thet ned b deta	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac								pacco use	co use contribute to the cause of death?		
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use a	Completed by	DIABLAS METERITUS							1 🗆 Ye	Yes 2 No 3 Probably 4 Unknown			
<u></u>									24a. Was a	Was an 24b. Wei		e autopsy findings available		
æ										autops	ned?	prior to co death?	ompletion of cause of	
Division of Vital Records, P.O.		ပိ	25. Was case referred to medical					26 Place	of Death		2 SkNo	1 🗆 Yes	2 No	
		ToB	examiner?	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								(64)		
		Certification; T	27. Manner of Death	28a. Date of Injury 28b. Time of						8d. Describe ho		·· y)		
			1 Natural 5 Pending 2 Accident investigation	(WORLI, Day real)	injury			K? Yes 2 □ No						
Divis			3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					2	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										stated. to the cause(s)	
	To ti To ti Comp	Ž	29b. Signature and title of certifier 29c. License number							2	29d. Date signed (Month, Day, Year)			
}	6		30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) (2 page Donaldson M. D. 9/2 Seton Deive Cumberland 31. Date filled (Month, Day, Year) APR 192006 32 Registrar's Signature							Upri	L 14T	1 2006		
			30. Name and address of phison who co		em 23a) (Type,	Print)			1	W	1		0.00	
	nds		GRagg Donalds	son M. D.	912 3	seto.	n De	ive	Cu	mberla	and	Mary	land	
5 40	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 200	32 Registrar's Sig	nature	asti.	,					V		

			1 - For State Registrar	State of	Maryland / De	partment e <i>rtificate</i>			Mental H	ygiene Reg. No.	06	1389	97
	Physici		Decedent's Name (First, Middle, La Irvin Wolford	ist)					2. Date of D		2006 ^{ear}	3. Time of 12:15 P	Death M
	/Medic Examir		4a. Facility Name (If not institution, given Frostburg Village Nur		•		Fr	ocation of De	eath		ounty of Deat	th	
	Funeral Director			Sex M 2□F	7. Age (In yrs. last birthda 79 Yrs.	Months	1 Year Days	If Under 24 H Hours M		irth 1926	9. Birt Mary	hplace (State or land	[,] Foreign
	Maryland a-fehow	ctor	10a. State 10b. County Maryland Allegan	y	10c. City, Town or Frostburg	Location						10d. Inside Cit	
	h with the 23a or 28	Funeral Director	10e. Street and Number 19311 Lo	wer Consol	Road, N.W.	10f. Zip 2153				10g. Citizer U.S.A.	n of What Co	ountry?	
9600	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Itame 23a or 28a-1 ehow ther, Ita Medical Exacticat trust be incitied at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford 1 XYes If Yes, Give Year or Da	tes: WWT	1 ☐ Yes 2	No	Specify:	(Specify Yes or Nerto Rican, etc.)	Sp	Race - Ame Black, White White	e, etc.	
Baltimore, Maryland 21215-0036	be filed within 72 ha ital Hygiene. d other than "netui event, Ita Maulcai	Completed by	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-	(Gi	cedent's Usua ve kind of won . DO NOT us	k done du	ion ring most of v	vorking		ghway	,	
yland	e d is d	To Be	17. Father's Name (First, Middle, Last Harry E. Wolford					Alice Ma	arie Skidme	ore			
e, Mar	nd 2 s lith ar 27 is r treu		19a. Informant's Name/Relationship (Ruby Wolford	Туре, Print) wife	19b. Ma 19311 20b. Place OPOs	Lower C	onsol		Rural Route Num. estburg	Mary	land	21532	
timore	Pages nent of ant: If if ary or o		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	(y)		ematory or ot	her place)		Date 14-Apr-06 (ion - City or ind Ma		
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Lice	Jurit			neral I	Home, 57	Frost Ave.,		g, MD 2	1532	
8760,	The law requires that the death certificate be executed with the death certificate be executed with a second be detached for use as the burial-transit remains the detached for use as the burial-transit with the second be detached for use as the burial-transit with the second be detached for use as the burial-transit with the second burial-	dicai Examiner	23a Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	a Due to (c	or as a consequence of): or as a consequence of): or as a consequence of):		1 RY	11656	co o roopiacity	a. ()		Approximate Interval Betwoonset and Donest a	reen
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live bir	int at time of death	Ectopic pre				23d	. Date of deli Month	•	ear
	w requires that been signed b should be deta	Ď	Part II. Other significant conditions of	ME	CLIFUS			in Part I.		tobacco use Yes 2 □ N		the cause of de	
al Records,		Completed	CEREBRUN	Men	its te	a'den	J-		24a. Wa auto peri 1 🗆 Yes		prior to death?	topsy findings as completion of car 2 No	vailable use of
Division of Vital	ding Phys h. After this funeral dir	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of (Month	patient 2 EP/Outpati f Injury , Day Year) 28b. Time Injury	of 28	Other: Ic. Injury a Work? 1 Ye	Nursing	eath (Check only Home 5 Res 28d. Describe	idence 6 (ccurred	ral Route Numb	
Div	Hospitel or Attend 44 hours after death Funerel Director: , tely filled in by the f		4 Homicide determined	buildin	g, etc. (Specify)				City or To	wn, State)			θ7,
	To the Hospitel or Attent within 24 hours after deal To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exar 29b. Signature and title of certifier	niner: On the bas and manne	pest of my knowledge, de sis of examination and/or er stated.	investigation,	in my opir	nion, death oc	ce, and due to the	date and pla	d manner as ice, and due igned (Month	to the cause(s)	
4	(who		7.13	wellow		0	260				-	2006	
	(VA)		30. Name and address of person who Harit 5. Sidho 31. Data Flad (Month Day Koor)	9:	25 Bishipp h		d. (Cumber	land, MI	2150	02		
State Registrar APR 1 3 2006 32. Registrar's Signature													

			1 - For State Registrer	of Maryla		artment of He tificate of D			ene g. No. 0 0 5	13898
	Sept. Sept. Se	. 6	Decedent's Name (First, Middle, Last)					O Davi of David		3. Time of Death
in.	Physici /Medic		Joseph Brian Weisge	rber				April 1	9 2006	2:10a.m
	Examin		4a. Facility Name (If not institution, give street and n	number)		4b. City, Town, or L	ocation of Death	ו	4c. County of Dea	ith
			7712 Fairplay Road	1 7 4 4-	/ 1 1 2 3		onsboro If Under 24 Hrs.	0.0 (0.1		on County
	Funeral Director		5. Social Security Number 6. Sex 1 ★ M 2 F	7. Age (in y	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)
3-	# -c		219–48–5692 Usuaf Residence of Decedent	J.				Dec 2	1947 Pen	nsylvania
	rylanc how		10a. State 10b. County	10c.	City, Town or Lo	cation				t0d. Inside City Limits
	Ba-f-	cto	Maryland Washington		Вос	onsboro				1 ☐ Yes 2X No
	or 24	Director	10e. Street and Number			10f. Zip Code	1717	10	g. Citizen of What C	
	• 23e	rai	7712 Fairplay Road		11.0		21713		U.S.A	
(O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show expiritury or other traumatic event. The Medical Examinar must be muitiled at once.	Funeral	Armed	ecedent Ever in Forces? s 2 ∏ No Give		Vas Decedent of Hisp Yes, specify Cuban,		o Rican, etc.)	Black, Whi	te, etc.
Maryland 21215-0036	raf', c	1 by	3 Widowed 4 Divorced If Yes, C	Dates:		☐ Yes 2☐XNo	Specify:		Specify: W	hite
5	72 h 'natu	Completed	 Decedent's Education (Specify only highest grade completed 	1)	(Give	ent's Usual Occupati kind of work done du	ion iring most of wor	king 1	6b. Kind of Business	Andustry
2	within and and and and and and and and and an	d m		(1-4or 5+)		OO NOT use retired)			0.16.5	
D	filed Hygie ther	ပိ	12 17. Father's Name (First, Middle, Last)		Tru	uck Driver		ne (First, Middle, M	Self Em	broked
au	d be entai ked o	To Be	Joseph Aloysius Weis	merher			Data	icia Mari	e Byrd We	icaorbor
ary	shoul nd M mar	_	t9a. Informant's Name/Relationship (Type, Print)	gerber	19b. Maifin	g Address (Street an			City or Town, State,	
Ž	alth a alth a 27 io		Frances Loretta Weisger	rber (w	rife) 77	712 Fairpl	ay Rd.	Boonsboro	Maryland	21713
altimore,	of He of He ritem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from		. Place of Dispos cemetery, crem	sition (Name of patery or other place)		Date 2	Oc. Location - City or	Town, State
Ĕ	Pag ment ant: i		4 Donation 5 Other (Specify)	State	mithsbur	g Cremato	ory 4-2	0-2006	Smithsbur	g Maryland
Balt	eparti eparti nport ny inj		21. Signature of Funeral Service Licensee	0	22.	Name and Address	of Facility Do	uglas A.	Fiery Fun	eral Home
	40 F e d		Lanu o lan	Sey Ji		31 Easter	n Blvd.	N. Hager	stown Mar	yland 21742
п			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line	ath. Do not ente	er the mode of dying,	such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
300	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	lu	mg	Car	rcer			month.
	Examiner		Due to	o (or as a cons	equence of)					
		er	Sequentially list conditions, if any, feading to immediate Due to	o (or as a cons	equence of):					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó	e exection ar			o (or as a cons	equence of):					
8760	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	d							
9 ×	ding p	/Mec	fF FEMALE: 23c If yes o	utcome of preg	202004					
Вох	eath certific attending p	ian	in the past 12 months?	birth 2 ⊟Fo	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
o.	that the de led by the a detached	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unk			Other (specify)				
a, a	The law requires that the te has been signed by though 2 should be detached.	by PI	Part II. Other significant conditions contributing to	death but not r	esulting in the un	derlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	w requires been sign should be	ed b						Yes	2 □ No 3 □ P	robably 4 Unknown
000	has bei	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Ĭ.		E O						performe	ed? death?	2 □ No
ī	ysiclan: Th	Be (25. Was case referred to medical examiner?					th (Check only one)		
	Physi this c	2			☐ ER/Outpatient		4 🗆 ivursing n		ce 6 Other (Spe	ocify)
Division of	ding f	lon	1 Naturaf 5 ☐ Pending (Mo	e of Injury onth, Day Year)	28b. Time of fnjury	28c. Injury a Work? M 1 ☐ Ye	it es 2 □ No	28d. Déscribe how	rinjury occurred	
<u>is</u>	i or Attendi after death. Director: A in by the fu	fica	3 Suicide 6 Could not be determined 28e. Plac	ce of Injury - Al	home, farm, stre			28f. Location (Stre	et and Number or R	ural Route Number,
Š	al or safter	Certification:	4 Homicide determined buff	ding, etc. (Spe	cify)	,,,		City or Town,	State)	
	To the Hospital or Attending Physician: whith 24 hours after death this certific To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the Check only one) 2 Medical Examiner: On the and ma	basis of exami	nowledge, death nation and/or inv	occurred at the time estigation, in my opin	, date and place nion, death occu	, and due to the cau	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	inner stated.	(IA)	29c. License r	number	290	d. Date signed (Mont	h, Day, Year)
	- 2 - 0		H. J. Ha			NI	+61.	73 /	100:0	20 200L
			39. Name and address of person who completed car	use of death (fi	em 23a) (Type, F	Print)	104		Til a) A.M.
5	8-15		Hind Hamdan,	mD;	1130	OPA	LCI	· / 1998	Muotar	M) 21/14(
	Sta	_	SH. Date filed (Month, Day, Year) 32.	Registrar's Sig	nature	All I		1	/	
130	Registr	टा	MEN NO 2000 12	Mary Michael	AS " SEE SEE	in dies American				

			1- For Amend Items 23aState-of Mandand Department of Health Mandand Certificate of Death Certificate of Death		jiene) () ()	13899
	Physic	an	Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
	/Medi	cal	DONALD ROWLEY ZIEGLER	4.	16 2006	2259 M
-	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death AND AND AND AND AND AND AND AND AND AND	_	4c. County of De	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 HS	8. Date of Birth		irthplace (State or Foreign
L	Director		215-42-9546 124 M 2 F 60 Yrs. Months Days Hours Min.	(Month, Day, Feb. 9,	rear) (ountry)
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28s-1 show event, the Madical Examinar must be multiled at	to	Maryland Wicomico Salisbury			1 ☑ Yes 2 ☐ No
	th the	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What (Country?
	ath wi	rai	830 S. Schumaker Dr. Apt. 101 21804		USA	
	teme rerra	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Properties 2 No	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
980	within 72 hours after ene. than "natural", or ite	Ď	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ 967 − 70 1 □ Yes 2 ☑ No Specify:		Specify:	71
21215-0036	72 hor	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	7 hite s/Industry
2	hen hen	mple	Elementary/Secondary (0-12) College (1-4or 5+)			County Dept.
2	filed with Hygiene other the		Tamily Investment Programment		of Social	Services
Maryland	ental ked o	To Be	Donald M. Ziegler Doris	(FIRST, MIDDIE, N		
ary	2 should be and Mental Is marked of aumatic ever	-	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rural</i>	l Route Number,	Sho City or Town, State,	
Σ	1 and 2 Health a em 27 le		Barry Ziegler/ son 99 Atwood Drive - Gerra			
Baltimore,			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location · City o	
E E	rtmen rtant: njury		4 Donation 5 Other (Specify) Salisbury Crematory 04/18/	2006 S	alisbury, M	aryland
Ba	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 JOLLEY MEMORIAL C		Road - Sa	alisbury, MD 21801
п			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Spontaneous Retroperitoned	respiratory arre	est,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	CONG P	\ \	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	200	EXAMINER	
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	OVE WEDICA		
	acuted ind transii	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that intitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
60,	ificate be executed g physicien and as the burial-transit	E	resulting in death) Last Due to (or as a consequence of):			
68760,	ficate physics the	edicai	d	_		1
Box (eath certifi attending p	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	liven
œ.	death	sicia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No 1 Other (specify)		Month	Day Year
<u>Ф</u>	res thet the de igned by the a be detached f	Phy	3 L CHAICHT			
Division of Vital Records, P.O.	The law requires that the death cert ite has been signed by the attendin bage 2 should be detached for use	Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENA FAILM RE			o the cause of death?
Ö	s been sign	olete		24a. Was an		utopsy findings available
<u> </u>	: The law cete has page 2 s	E		autopsy perform	ed2 prior to death?	completion of cause of
/ita	iiclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner? 26. Place of Death		The state of the s	s 2□No
5	this al di	္ရ	1X Yes 2X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 🗆 Resider	nce 6 Other (Spe	ocify)
<u></u>	or Attending Physician: for death. irector: After this certifical by the funeral director.	t on	Natural 5 Pending (Month, Day Year) Injury Work?	Bd. Describe how	w injury occurred	
NSI/	Atten r deat sctor: by the	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm street factory office	3f. Location (Stre	eet and Number or R	ural Route Number
á	7 2 2 2	Certification;	4 Homicide building, etc. (Specify)	City or Town,	State)	ordin rioble rivaliber,
	To the Hospital of within 24 hours of OTO the Funeral D completely filled in	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and a local examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the car d at the time, dat	use(s) and manner at te and place, and du	s stated. I to the cause(s)
	To the within comp	ž	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mont	h, Day, Year)
	om)) /a 31, 40 D 4 6 9 62	- F	APRIL 1	6,2006
·	NA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMAYS SHIKAZZI, M.D. 31545 WINDACE PICK	4 51		
	Stat Registra	e	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMMY SHIKAZII, M.D. 31545 WINAUplace PING 31. Date filed (Month, Day, Year) APR 1 9 2006 32. Registrar's Signature			~ /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item # 14,17, perFH,9855,5/11/06 11 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 200^{Year} Adar Fatma Jale 27 0154a M /Mediča/ 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist N.H. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 7-18-13 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 219-82-5495 Yrs. Turkey Director 92 Usual Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 □ No Director Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ traumatic event, the Medical Examiner must be 21208 USA 31 Woodholme Ave. or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. White 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specity: þ If Yes, Give Year or Dates: Specify Black 3 Widowed 4 □ Divorced "natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs. NA s 1 and 2 should be filed w f Health and Mental Hygier Item 27 is marked other th Unemployed 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be -Nurtoph-Ziya Nurtopu Ismet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Item 27 is 31 Woodholme Avenue, Baltimore, Md. Son Berrak Adar 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If eny Injury or Md. Nat. Mem. Pk. 4-28-06 4 Donation 5 Other (Specify) Laurel, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 dug l on March F.H. East women 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ischemic cardionyopathy disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of) Examiner burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice P 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

The law requires that the death certificate be executed ed by the attending physician detached for use as the buria Box 68760 4.27.06 0154 AM cete has been signed in page 2 should be det certificete of Vital or Attending Physician: After this certification death. Director within 24 hours after of To the Funeral Direc completely filled in by filled in by

with the Maryland

filed within 72 hours after

Pages

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 nw, APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Werks St Baltimere my

31. Date filed (Month, Day, Year) State

29a. Certifier

3 2006



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Registrar

2006

Usual Residence of Decedent 10a. State 10b. County	Curtis N. Ada street and number) A Survivious T. Age (In yrs. last T.	birthday) Yrs. 4b. City, Town, If Under 1 Yea Months Days Town or Location to 10f. Zip Code	Hours Min. 1215 Hispanic Origin? (Spoan, Mexican, Puerto	8. Date of Birth (Month, Day 3-28-	Day Y A C County of 4c. County of 1931	Death Death Death Death Death Death Death Death Ga 10d. Inside City Limits 1 X Yes 2 No at Country? American Indian,
5. Social Security Number 5. Social Security Number 254-46-7897 Usual Residence of Decedent 10a. State 10b. County Md No. Street and Number 3503 Hilton Road 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade 12th grade 17. Father's Name (First, Middle, Last) Joe N. Adams 19a. Informant's Name/Relationship (To Jean Adams - Wife	7. Age (In yrs. last 10c. City, T Ba1 12. Was Decedent Ever in U.S. Amed Forces? 1 [2] Yes, Give Year or Dates: Jocation Le completed) College (1-4or S+)	birthday) If Under 1 Yea Months Days Town or Location to 10f. Zip Code 2 13. Was Decedent of If Yes, specify Cull 1 Yes 2 X No. 6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire)	1215 Hispanic Origin? (Spoan, Mexican, Puerto	8. Date of Birth (Month, Day 3-28-	4c. County of Year) 1931 Og. Citizen of Who U S A	Death Death Death Death Death Death Death Ga 10d. Inside City Limit 1 XYes 2 N at Country? American Indian,
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Joe N. Adams 19a. Informant's Name/Relationship (T) Jean Adams - Wife					Dentist	ry
19a. Informant's Name/Relationship (T) Jean Adams - Wife			18. Mother's Name		Maiden Sumame)	
	/pe, Print)	9b. Mailing Address (Stree	Viola V		City or Town Sto	ata Zin Cardal
20a Method of Disposition		3503 N. Hil		Balto, N		te, zip codej
1 ABurial 2 □ Cremation 3 □ F	Removal from State ceme	of Disposition (Name of stery, crematory or other pla	ice)	Date	20c. Location - Cit	y or Town, State
4 □Donation 5 □ Other (Specify)	Wood	llawn Cemeter		-2006	Balto Co	, Md
21. Signature of Funeral Service Licens	"BK.	22. Name and Addre	ess of Facility Ma 00 Wabash	•	West Balto, M	fd 21215
23a. Part 1 Enter the disease, or complished, or heart failule. List only or	ications that caused the death. D					Approximate
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMOMÍA De to (or as a consequence					Interval Between Onset and Death
Sequentially list conditions,	Sepsis					1 nevotes
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (as a consequence	1				
resulting in death) Last						1 ments
	1					
IF FEMALE:	3c. If was outcome of programmy					
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 3 Ectopic pregnancy 5 Other (specify)	4		23d. Date of Month	delivery Day Year
Part II. Dther significant conditions con	tributing to death but not resulting	in the underlying cause giv	ren in Part I.	23e. Did toba	acco use contribut	e to the cause of death?
				1 🗆 Yes	s 2 □ No 3 □	Probably Winknown
				autopsy	prior	autopsy findings available to completion of cause of
DE Was case referred to medical				1 Yes	ed? deat	h?
examiner?	ospital: Inpatient 2 EB/C	Oth				
27. Manner of Death						ipecify)
2 Accident investigation		M 1 🗆				
4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	2	8f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin		ge, death occurred at the tir and/or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cau	use(s) and manner	r as stated. due to the cause(s)
29b. Signature and title of certifier					J.	
PO Plano	roltain	DOM	D 6 34 a	2	4/2-1	06
0. Name a ddress of person who con	mpleted cause of death (Item 23a)	(Type, Print)		1	110010	11.
11. D (le filed (Month, Day, Year)	320Registrar's Simature	LD Since	ti Herpin	tal of	Bali	Gorove
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Dther significant conditions conditions conditions are saminer? 1 Yes 2 No H 7. Manner of Death 1 Natural 5 Pending investigation 1 Natural 1 Natural 2 Accident 3 Suicide 6 Could not be determined 19a. Certifier (Check only one) 9b. Signature and title of certifier 0. Name and ddress of person who conditions of the could not be determined	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2art II. Other significant conditions contributing to death but not resulting learning large	Due to (fir as a consequence): d. FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause gives a summer? 1 Yes 2 No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause gives a summer? 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other (specify) 28a. Date of Injury (Month, Day Year) Injury 28b. Time of Injury (Month, Day Year) Injury No 1 28c. Injury 28c. Injury No 1 28c. Injury 28c. Injury No 1 28c. Injury 1 28c. Injury 28c. Injury 1 28c. Injury 28c. Injury 28c. Injury 1 28c. Injury No 28c. Injury	Due to (Ar as a consequence): d	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 23c. Did tob: 23c. Did tob: 23c. Did tob: 23c. Did tob: 23c. Did tob: 23c. Did tob: 23c. Did tob: 23c. Did tob: 23c. Did tob: 24a. Was an autopsys 24a. Was an autopsys 25. Was case referred to medical examiner? 25c. Place of Death (Check only one) 26c. Place of Death (Check only one) 27c. Manner of Death 1 Yes 2 No 28c. Dinjury (Month, Day Year) 28c. Injury at Work? 28c. Place of Injury - At home, farm, street, factory, office 28f. Location (Street) 28c. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the can and manner stated.	Due to (in as a consequence f): d. 23c. If yes, outcome of pregnancy in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Eactopic

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	Physici	20	1. Decedent's Name (First, Midd	le, Last)							2. Date of De	ath Da	v v	ear	3. Time of Death
4	Physici /Medio		AZLENE	r	MARSH	+17 7	ABRA	HAY	ns		APRIC			006	01:10 AM
X	Examir	er	4a. Facility Name (If not institutio				4b. City, T					40	. County of	Death	
			JOHNS HOPKINS 5. Social Security Number	BAYVIEW I					If Under 2						N/A
	Funeral Director		212-40-5189	1 M 2 M F	7. Age (in yr.	s. last birthday) 5 Yrs.		Days	Hours	Min.	8. Date of Bir 02/06/	n 1 4211	9	. Birthpli Count	ace (State or Foreign (Ty) MD
			Usual Residence of Decedent	Λ	0						02/00/	1711			110
	how		10a. State 10b. County	′	10c. C	City, Town or Lo	ocation							10	d. Inside City Limits
	e Ma	cto	MD E	BALTIMORE				E	BALTI	MORE	=				1 ☐ Yes 2 🂢 No
	ih th or 28	Director	10e. Street and Number				10f. Zip C					10g. Ci	tizen of Wha	at Count	
	• 23•	rai	2506 LIGHTFOO						21209						USA
	ltem Item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Mar	Armed F	cedent Ever in orces? 2 X No	U.S. 13.	Was Decede If Yes, specif	nt of Hisp y Cuban,	panic Orig , Mexican,	in? (Spe Puerto	ecify Yes or No Rican, etc.)	•	14. Race - Black,	America White, e	
936	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Vac C	ive		1 ☐ Yes 2(X No	Specify:				Specify:		WHITE
Ď	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. 4 of ther then "natural", or iteme 23a or 28a-f ehow other then "natural", or iteme 23a or 28a-f ehow event. I've Medical Exartical metal be notified at	ted	15. Deceder	it's Education		16a. Dece	dent's Usual	Occupat	ion			16b. K	and of Busin	ness/Indi	ustry
21	within 7 ene. then "r	pje	Elementary/Secondary (0-12)	st grade completed	(1-4or 5+) <u>4</u>	life.	kind of work DO NOT use	retired)	nng most	of workii	ng	01		_	
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pur		Be	17. Father's Name (First, Middle,	Last)		LEVEN	i	1	I DA	's Name	(First, Middle.	Maiden	Sumame)		RODMAN
Ž	hould d Mer marke	ဠ	ROBERT 19a. Informant's Name/Relations	thin (Tuna Print)				Cton at an		0	10-11-	0.7	T 0:		
Maryland 21215-0036	s 1 and 2 should f Health and Mer frem 27 is marke other treumatic		STANLEY ABRAHA		BAND						l Route Numbe - BALTII				
	s 1 ar		20a. Method of Disposition	-		Place of Dispo	sition (Name	of	1		ate		ocation - Cit		
Ę	2 = 5		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State BA	cemetery, crei LTIMORE	•			5/02	2/2006	REI	STERS	TOWN	N. MD
Baltimore,	permit. Pag Depertment Importent: any Injury o		21. Signature of Funeral Service	• • • • • • • • • • • • • • • • • • • •	(LEVIN				
Φ_	Depe Impo any le		Toleto.	- Lun		> 8	900 RE	EIST	ERST0	WN F	ROAD -	PIKE	SVATOL		D 21208
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea	ath. Do not ent	er the mode	of dying,	such as c	ardiac o	r respiratory ar	res	16	CON EI	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a	SEPSIS								BY ME	W.	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):					J/S	1561 VS61			
		e.	Esquentially list conditions, if any, leading to immediate		CON as a conse		RE				MIFICA	10.			
	nsit	nine	Cause (Disease or injury				0) / 6								
<u> </u>	execun n and ial-tra	Examin	that initiated events resulting in death) Last		(or as a conse		304 3	S 074F	-/+C=	40	28/4 13	UNZN		-	
68760,	licate be executed physicien and s the burial-transit	dicail		d											
	ntifica ng ph as th		15.55.44.5	1											
Вох	death certifi te attending I ad for use as	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic pred	ากลกсง				19	23d. Date of		
Ö.	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at time of		Other (spec						Month	С	Day Year
P.O.	that the de ned by the a detached t	Phy	Part II. Other significant condition	200 contribution to	death but not re	culting in the u	adochina anu		in David		220 Did to	bassa		1 a 1 a 1 b a	
g o	Se jo e	1 by	Tall in Other Signmount Contain	one contributing to	Jealii Odi ilot le	suming in the di	ndenying cau	ise given	iii raiti.			es 2	_		cause of death?
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Records,	he lay	Completed									24a. Was autop perfor		240. Wer prior deat	to com	sy findings available pletion of cause of
重		o C	25. Was case referred to medica		<u>-</u>				C Place	of Dooth	1 Yes	2 🔁 No		Yes 2	!□ No
>	Physician: rthis certifica ral director, I	ToB	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA	Othor			Check only on the 5 Resid		6 □Other /	Spaciful	
0	19 Ph ter th		27. Manner of Death	28a. Date		28b. Time of		: Injury a Work?			8d. Describe h			opecity)	
<u>0</u>	Attending ir death. ector: After by the fune	atic	1 □Natural 5 □ Pendir 2 ☑ Accident investi	gation 03-0	2-2006	quiy	PM		s 2 🛛 N	0	SED FIR	E F	ion A	CA	NALE
-	or Atten after deatl Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Plac	e of Injury - At I	nome, farm, stri	eet, factory, o	office		2	8f. Location (S City or Tow	treet an n, State	d Number o	r Rural I	
	pital o					HOME				2	2506 LIG	HT F	067 DE	SUL	
	To the Hospital or Attending Phenium within 24 hours after death. To the Funeral Director: After the cumpletely filled in by the funeral	Medical	29a. Certifier 1 Cartifyir (Check only one) 2 Medical	ig Physician: To th Examiner: On the i and mar	e best of my kn pasis of examin nner stated.	owledge, death ation and/or inv	occurred at restigation, in	the time, my opin	date and ion, death	place, a occurre	ind due to the o ed at the time, o	ause(s) late and	and manne place, and	r as stat	ted. he cause(s)
	o the	Me	29b. Signature and title of certifie	and man	/			_icense r					e signed (M		
	- 5 - 6		• (,)	1	~ \		_			27			_		
	10	1	30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type.									
_	\			ILNER	4940	Enso	EN,	AVE	NVE	B.	ALTIM	ore	- ml	2	1224
	Sta	-	31. Date filed (Month, Day, Year)	006	Registrar's Sign	ature	2						,		
	Registra	al I	MIAI U 0 Z	UUU AUUU	100	17									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year RALENE BEATRESS BARNES APRIL 29. 2006 8:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SAINT JOSEPH TOWSON MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 04-28- Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Days Hours 52 Director 215.60.D724 MO Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at Director 1 ∏Yes 2 No BALTIMORE MD WINDSOR MILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 GEMISTONE COURT 21244 ЦSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【图 No If Yes, Give Year or Dates: or Items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) 2 YRS Elementary/Secondary (0-12) 12 TH GRADE CLAIMS LIFE INSURANCE 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 is marked oth Be 18. Mother's Name (First, Middle, Maiden Surname) JAMES JONES PHYLISS MATTHENIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE BARNES . SR GEMSTONE CT., WINDSUR MILL Mo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If any injury or once. 4 □Donation 5 □Other (Specify) 05.05.06 BALTIMORE, IND LOUDON PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE moon 5151 BALTO. NATU PIKE, BALTO. MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner CLOSTRIDUM DIFFICILE DAYS Squartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Examir Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GASTRIC BYPASS SURGERY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2X No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 30 106 00060495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON 7601 FAN DSLER DRIVE 21204 M.D 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 0 3 2006 Registrar

	·-· <u>-</u>		for State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmer ertifica			nd Mental Hy	ygiene Reg. Nö.	005	13904
100	Physic	ian	Decedent's Name (First, Middle, La.		lhant Dana	J			2. Date of D	eath Day	Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give	Eugene A e street and number) SPIPAL	ibert Band	-	Town, or	Location of I	APRIL Death	4c. Co	2006 ounty of Death	6: 20 A A
\$ \frac{1}{2}	Funeral Director		5. Social Security Number 6. S 217.22.4561 Usual Residence of Decedent	ex □ M 2 F	(In yrs. last birthday 78 Yrs.) If Unde Months	r 1 Year Days	If Under 24 Hours	Min. 8. Date of B (Month, D	ay, Year)	9. Birthp Cour	place (State or Foreig htry) Maryland
	/2 hours atler death with the Maryland natural; or Itema 23a or 28a-f show iteal Examinar trust by notified at	Director	10a. State 10b. County	ward	10c. City, Town or L	ocation	EII	icott City	•			0d. Inside City Limits 1 ☐ Yes 2√☐ No
	a or 2	Dire	10e. Street and Number			10f. Zij	Code			10g. Citize	n of What Cour	•
	ne 23	Funerai	3004 North Ridge Road	12. Was Decedent E	ver in U.S. 13	Was Done	dent of Hi	2104		2 14	U.S.	
)U30	/2 hours atter death with the Maryla natural', or Itema 23a or 28a-f shov dical Examinar trust by retitled at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		If Yes, spe		Specify:	n? (Specify Yes or N Puerto Rican, etc.)		Black, White,	
7	within ane. than *	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	(Give	dent's Usu kind of wo DO NOT u	ork done a se retired,	luring most o	f working	16b. Kind	of Business/Ind	,
and	ntal Hyg	To Be Co	17. Father's Name (First, Middle, Last)	mi) Bandy			IVI		Name (First, Middle Ruth	e, Maiden Su Estella I	,	
a)	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ing Address	(Street a	nd Number o	or Rural Route Numb	ber, City or To	own, State, Zip	Code)
a)	teal teal		Mr. Eugene L. Bandy 20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐	Regioval from State	20b. Place of Disponentery, cre	osition (Na)	me of		Bel Air, Maryl	20c. Locat	tion - City or To	
Dalti	permit. Pages Department of h Important: If ite any injury or of once.		4 ☐ Onation 5 ☐ Other (Specify 21. Ignature of Funeral Service Licen	88	Maryland -G	ar Nson r S	Forest Black F	s of Facility uneral Ho	04/26/2006 ome, P.A.			st, Maryland
	hysician hysician and business and business that the private state of th	ai Examiner	23a. Part1. Enter the disease or compensor, or heart failure. List only of Imhediate Cause (Final disease or condition esulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. PROSTA Due to (or as a	he death. Do not end. PTE CA consequence of): consequence of):	ter the mod	le of dying	, such as ca	bia Pike Ellico rdiac or respiratory a	arrest,	15 21043	Approximate Interval Between Onset and Death UTAMES
	e attending of for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	Fetal death 3	□Ectopic pr □ Other (sp				23d	. Date of deliver	ry Day Year
	n signed b	<u>م</u>	Part II. Other significant conditions co		not resulting in the u	nderlying c	ause give	n in Part I.		tobacco use Yes 2 □ N		e cause of death?
Or Attending Object of the Control o	this certificate has been si	Completed	HYPENTEN.	S10~.					24a. Was auto pend 1 □ Yes	an 2 psy prmed? 2 No	death?	osy findings available apletion of cause of
	certifi	Be	25. Was case referred to medical examiner?	Hospital:			Othou		Death (Check only			
oding Ohm	after death. Director: After this in by the funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time o		8c. Injury Work	4 🗀 Nursir	ng Home 5 Resi 28d. Describe)
. ;	, 2 = = =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc.					City or To	wn, State)	umber or Rural	
the Hoon	within 24 hours at To the Funeral D completely filled in	Medical	one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	vestigation,	in my opi	nion, death o	occurred at the time,	date and pla	ce, and due to	the cause(s)
1	2 2 3		29b. Signature and title of certifier MACCOH			290	License Pl	676	6	APML	2-2, 2	oay, Year)
1	U		30. Name and address of person who constituted MASON (31. Date filed (Month, Day, Year)	ompleted cause of deal (ACNOS) 32. Megistrar	ith (Item 23a) (Type,	Print)	10NS	ANS,	BALTIMO	ne M	0,20	129.
	Sta Registr	- 4	MAY 0 3 21	BY.	s Signature	Balle						

BANDY, BUGGINE

			1_ State	land / Department of Health and Mental Certificate of Death	6000 13303
			Registrar 1. Decedent's Name (First, Middle, Last)	D 2. Date	Reg. No. of Death 3. Time of Death
	Physici /Medi		Louis		vi- 27 7006 12:25 AM
	Examir	er	4a. Facility Name (If not institution, give street and number)	g (enter Saltimore	4c. County of Death
t	Funeral		5. Social Security Number 6. Sex 7. Age (In		of Birth th, Day, Year) 9 / 1921 9 Birthplace (State or Foreign Country) MD
	Director		215-18-9422 1□ M 2♥F 84	Yrs. 12/	/9/1921 MD
	show	ō	10a. State 10b. County N/A	Baltimore City	10d. Inside City Limits XIZYes 2 □ No
	with the had or 28a-1	Direct	10e. Street and Number 1155 Haubert Street	10f. Zip Code 21230	10g. Citizen of What Country?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "netural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be routhed.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 □ Yes 2 ☑ No Specify:	or No- 14. Race - American Indian,
215-0036	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
212	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	Own Home
	e filed al Hygi d other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, N	fiddle, Maiden Surname)
Maryland	should be filed within 72 hours ind Mental Hygiene. s marked othar than "natural", umatic evant, I'va Medical Exa	ို	Peter Lenivy 19a. Informant's Name/Relationship (Type, Print)	Johanna 19b. Mailing Address (Street and Number or Rural Route N	Hankovic
	f and 2 sho Health and tem 27 is m			er 1155 Haubert Street, B	Saltimore MD 21230
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.	Say and a	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Db. Place of Disposition (Name of cometer, crematory or other place) len Haven Cem May 2, 2	20c. Location - City or Town, State 0006 Baltimore MD
Balti	permit. Pag Department Important: I any injury o		21. Signature of State Change Victor D	Charles I Stowers F	uneral Home, Inc.
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	1501 E. Fort Ave., Ba	Itimore MD 21230 Approximate Interval Between
	Physician /Medical		disease or condition resulting in death)	acranial Nemovrhag	e Sodays
	Examiner		Due to for as a co	sequence of):	to dave
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
<u>,</u>	execute n and al-tran	Examiner	that initiated events resulting in death) Last C	rointestinal bleed sequence of):	20000
68760,	ficate be executed physician and s the burial-transit	edicail	d		
	sertifica ding pl	/Med	IF FEMALE: 23c. If yes, outcome of pr	agnancy	
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 pronths? 1	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
	ires that signed by	by	Part II. Other significant conditions contributing to death but no	resulting in the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	w require s been sign should b	Completed	seizure	24a.	
Re	rsician: The law s certificate has b lirector, page 2 s	Com	Hypertension	1 🗆)	Was an autopsy performed? /es 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death?
Vita	ician: certific ector.	Be	25. Was calle referred to medical examiner?	26. Place of Death Check of	on one
of	Phys ar this eral dir	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 28d. Desc	Residence 6 Other (Specify)
ion	ending Faath. or: After he funera	atlo	1 Anatural 5 Pending (Month, Day Yea 2 Accident investigation	r) Injury Work? 1 ☐ Yes 2 ☐ No	
Division	after de Directe	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (Si	At home, farm, street, factory, office 28f. Locat ecity) 28f. Locat	ion (Street and Number or Rural Route Number, or Town, State)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, death occurred at the time, date and place, and due to nination and/or investigation, in my opinion, death occurred at the l	o the cause(s) and manner as stated. ime, date and place, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
,	1		20 N	D 5-5-3-91	April 27, 2006
	5		30. Name and address of person who completed cause of death	Avenue, Baltimore, 1	Maryland 21227
	Sta Registr		31. Date filed (Mor/tr, Day, Year) Registrar's S	gnature	

		For State Registrar	State of Maryland		ment of Heal		ntal Hygien	71116	139	06
		1. Decedent's Name (First, Middle, La				2	. Date of Death	ay Year	3. Time of	
Physici /Medic		CONSTANCE	BARTH	oloma	16	A	pril 25	2006	526	PM
Examin	er	4a. Facility Name (If not institution, gi	· ·	4	b. City, Town, or Loca		4	c. County of Deat	h	
		UNION Memor 5. Social Security Number 6.	Sex 7. Age (In yrs. last	hirthday	BALT		. Date of Birth		nplace (State o	or Formian
Funeral Director			10 M 3DF 74			ours Min.	(Month, Day, Yea OV 15, 19	r) Co	untry) MO	ii i dieigii
v		Usual Residence of Decedent				100	10,777			
arylar ehow	_	10a. State 10b. County		own or Locat	BALTIME	000			10d. Inside C	ity Limits 2 No
the M 28a-1	Director	MD N/F			10f. Zip Code	orse	100.0	itizen of What Co		
with 3a or	ā	3306 WOOD	STOCK AVE		212	13	109. 0	U.S.A		
ITYIBING Z 1 Z 1 D-UUJO should be filed within 72 hours after death with the Maryland ad Mental Hygiene. marked other than "neture!, or iteme 23e or 28e-f ehow matic event, the Madical Examiner must be notified at	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	s Decedent of Hispan es, specify Cuban, Me		y Yes or No-	14. Race - Ame		
or Its	교	1 ☐ Never Married 2 ☐ Marned	1 TYes 27 No		Yes 2 No Sp		zan, etc.)	Black, White		
5-UU36 72 hours at neturel, or	d by	Widowed 4 □ Divorced	If Yes, Give Year or Dates:				1 401	u	hite	
in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give kin	t's Usual Occupation d of work done during NOT use retired)	most of working	160.	Kind of Business/	industry	
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= 0 = 0 =	Bec	17. Father's Name (First, Middle, Las			18.	_	First, Middle, Maide	,		
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Baitimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta important: if item 27 is marked any injury or other treumatic as		19a. Informant's Name/Relationship			Address (Street and N					
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nor ages ant of t: if it		3 Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special Control Co			ony or other place) SARY CENT					
Saitimore, ermit. Pages 1 ar appartment of Hea mportant: if Nem: iny injury or other nose.		21. Synatury of Funeral Service Lice		9 /10	ame and Address of	Facility	of Hame	· PA		
B F F F G		A faul yn.	Stella	HA	ame and Address of SLSTEIL 527 harra	ord Ro.	BA Ho.M	0 2123	4	
ALC: N		23a. P. 1. Enter the disease, or con	nplications that caused the death. Do						Approximat Interval Bet	ween
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/Medical Examiner		resulting in death)	Due to (or as a consequent	ice of):					2011	e circl
Examiner	1	Sequentially list conditions, if any, leading to immediate	b. Coronary Ar Due to (or as a consequence	tery	Disease				20 90	2003
nsi te	nine	Cause (Disease or injury							30 ye	as
execu in and	Examiner	that initiated events resulting in death) Last	c. Hypertension Due to (or as a consequence	ice of):						
cate be executed physician and ithe burial-transit	dicai	•	d		····					
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BOX 68 eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ath 3 Ec	topic pregnancy			23d. Date of deli Month		Year
that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	n 5∐O	ther (specify)					
HECONDS, P.O. BOX 61 The law requires that the death certific tite has been signed by the attending p bage 2 should be detached for use as 1	y Ph	Part II. Other significant conditions	contributing to death but not resultin	ng in the unde	erlying cause given in	Part I.	23e. Did tobacco	use contribute to	the cause of c	death?
COLDS, P w requires that been signed t should be det	ed by						1 Tes	2 □ No 3 □ Pr	obably 4	Ngknown
aw re	plet						24a. Was an	24b. Were au	topsy findings completion of c	available
VITAI KEC sician: The law s carlificate has t lirector, page 2 s	Completed						autopsy performed?	death?	2 ☐ No	ause of
/ITa	Be	25. Was case relerred to medical examiner?				Place of Death (0	Check only one)			
UNISION OT VITAL RECORDS, to Attending Physician: The law requires taltar death. Director: After this cartificate has been signed in by the funeral director, page 2 should be	၉	1 Yes 2 No		Outpatient			5 Residence		cify)	
ding F	ion	t Matural 5 ☐ Pending	(Month, Day Year)	Injury	28c, Injury at Work? M 1 ☐ Yes		a. Describe now inj	ury occurred		
JIVISION OF ARTENIA ARTENIA ARTENIA DIRECTOR:	fica	3 Suicide 6 Could not	28e. Place of Injury - At home	e, farm, street			Location (Street		ral Route Num	nber,
of or A saftar s aftar ad in by	Certification:	4 Homicide	building, etc. (Specify)				City or Town, Sta	re)		
DIVISION OF VITAL HOSPITED OF VITAL HOSPITED OF Attending Physician: The within 24 hours after death. To the Funeral Director: After this cartificate his completely filled in by the funeral director, page	edicai (29a. Certifier 1 ★ Certifying P	hysician: To the best of my knowled miner: On the basis of examination	dge, death or	courred at the time, da	ate and place, and	d due to the cause(s) and manner as	stated.	5)
the F hin 24 the F	Medi	one)	and manner stated.	225. 11143						7
Twit To To	-	29b. Signature and little of certifier	2		29c. License nun			ate signed (Monti		
1	1	30 Name and address of	completed cause of death (ter co	Sa) (Tues Di	1/1/243	0146	НР	nl 25,	2006	
6		30. Name and address of person who	D. 0. Union	M M	AT243	pital.	MD			
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	000	1100					
Regist		MAY - 3 2006	BOOK ST ST							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#26, perFit (2855.5 Mary) and / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 22 2006 Roger T. Bonev 4 9:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2812 Edgecomb Circle South Balto If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** X M 2□F Months Days Hours Min. 90 11-18-1915 Ñ.C. Director 220-03-8703 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 2 shourd be and Mental Hygiene.
Is marked other than "naturel, or iteme 23a or comis marked other than "naturel, or iteme 23a or comis marked other than "naturel," or iteme 23a or comis and the modified at the second of the modified at the second of the 1 XYes 2 No Directo N/A Balto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21214 5615 McClean Blvd USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 □ Divorced **Black** Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Security College (1-4or 5+) N/A Elementary/Secondary (0-12) Printer 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If tiem 27 is marked oth any lighty or other traumatic event ADE. Be Livingston Boney Ida Newsom ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Winesap Ct Apt F Catonsville, Md 21228 Annette Butler - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 5-1-2006 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West ellie 4300 Wabash Avenue Balto, MD 21215 eln 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1292110515 Physician TARC /Medical Due to (or as a consequence of). Examiner Sequentially list conditions. is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) ed by the attending physicien detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed pege 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only ne Assisted Living Hospital: Other: 4 Nursing Home 2 No P 1 🗌 Yes 1 Inpatient 3 DOA 2 ER/Outpatient After this funeral dis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No e Hospital or Attend 24 hours after death Funeral Director: 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Records,

Division of Vital

To the

72

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARM RU

3

31. Date filed (Month, Day, Year)

KENNETH CONETT

BALTHERA ND ZIZOI

			1 - For Stata Registrar		ryland / Depa <i>Ce</i>	artment rtificate				giene	06	13908
1 342	Physic /Medi		1. Decedent's Name (First, Middle, Las		Elizabeth	Bar	tee		2. Date of De. Month 4	Day	Year 2006	3. Time of Death 2:05 a M
	Exami		4a. Facility Name (If not institution, give 4114 Garrison I	oulevard		4b. City, T Bal		ation of Deat			ty of Death	1
in the	Funeral Director		5. Social Security Number 6. Sr 229-74-1824 1 Usual Residence of Decedent	X 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. Durs Min.	8. Date of Birt (Month, Da 9-24-	y, Year)	9. Birthi Coul	place (State or Foreign intry) Va
	the Maryland 28a-f show notified at	Director	10a. State 10b. County Md N/A		10c. City, Town or Lo	10f. Zip 0	`odo			10- 07		0d. fnside City Limits 1 X Yes 2 ☐ No
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exandret must be notified at ance.	Completed by Funeral Dl	4114 Garrison F 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grave)	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	16a. Deced	Was Decede If Yes, specif 1 Yes 2 Ident's Usual kind of work DO NOT use	2121 Int of Hispan y Cuban, Me X No Sp Occupation done during retired)		pecify Yes or No- p Rican, etc.)	US. 14. Ra Bla Speci 16b. Kind of E	A lice - Americ ack, White, ify: Blac	ean fndian, etc. ck
Maryland 21215-0036	hould be filed wil d Mental Hygien narked other th natic event, the	To Be Con	6th grade 17. Father's Name (First, Middle, Last) James Pryor	N/A	Но	usekee	18. I	oyce R		Maiden Suma	me)	
Baltimore, Maı	permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun ance.		19a. Informant's Name/Relationship (7 Wanda Bartee - D 20a. Method of Disposition 1 □ Burial □ Cremation 3 □ 4 □ Ponation 5 □ Other (Specify, 21. Signature of Funeral Service License	aughter Removal from State	20b. Place of Dispo cemetery, crem Metro Cre	Garri	ison_B of er place) Y	31vd 5-1-	Balto, I Date 2006 arch F/H	Vd 2121 20c. Location Catons	5 - City or To	wn, State
	Physician /Medical Examiner	l Examiner	23a. Parti. Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of Due to (or a) Due t	Consequence of):	430 er the mode 1 An C BL	of dying, suc	bash A	venue B	alto, N	Md 212	Approximate Interval Between Onset and Death Mulm
P.O. Box 68760,	The law requires that the death certificate be executed tie has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	d	Fetal death 3	Ectopic preg Other (spec				1	ate of delive	ry Day Year
rds, P	w requires that been signed t should be det	Ď	Part II. Other significant conditions co		not resulting in the un	iderlying cau	se given in F	Part I.		oacco use con	tribute to th	e cause of death?
al Reco		Completed	PULMONAR	1 EUBC	ousm			_	24a. Was a autops perform	neg!?	Were autop prior to con death? 1 \(\sum \text{Yes}	psy findings available appletion of cause of
Division of Vital Records,	ding h. After funer	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Maner of Death 1 Natural 5 Pending 2 Accident investigation	lospitaf: 1 Inpatient 28a. Date of Injury (Month, Day Y	28b. Time of		Other	Nursing Ho	me 55 Reside 28d. Describe ho	once 6 🗆 Oth)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (City or Fowr	, State)		Route Number,
	To the Hospital within 24 hours and the Funeral completely filled	Medical	one)	sician: To the best of r ner: On the basis of ex and manner stated	camination and/or inv	estigation, in	my opinion,	death occur	ed at the time, da	ate and place,	and due to	the cause(s)
			29b. Signature and title of certifier P	CIS M)	D	Cense numb	334	move	PML	a (Month, E	Nay, Year)
	5 Sta	te	30. Name and address of person who co	ag2. Registrar's	51万、	Print)	Ph. 1	3900	move	M	212	OI.
	Registr	ar I	MAY 0 3 2006	Parate Car	RS SUPPLY							

			1 - For State Registrar	State of Ma	aryland / Depa	artment of H			giene	13909
			Decedent's Name (First, Middle,	.ast)				2. Date of Dea		3. Time of Death
	Physicia	an	ALICE		RA	TTLE		Month	Day Year Zoo	6.02 PM
	/Medic		4a. Facility Name (If not institution, g	ive street and number)			Location of Death		4c. County of Dea	
	Examin	er				Balti			, , , , , , , , , , , , , , , , , , , ,	
			Bon Secours H 5. Social Security Number 6		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	hplace (State or Foreign
п	Funeral Director		212-26-8140	1□ M 2]X] F	84 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 04 0		NC
	, d		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	aryla shov	_	Toa. State							Y⊟Yes 2 □ No
	9 M	Director	MD NA		Baltimo					23
	th th	Jire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	th w	a	229 North Mou	nt Street	Apt 201		21223		U.S.F	
	dea	nel	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or it	by Funerai	1 Never Married 2 Married	1 ☐ Yes 🏋 🟋 If Yes, Give			Specify:			l - ale
8	ours ref.,		¾ ☐ ﴿ Vidowed 4 ☐ Divorced	Year or Dates:		- 2121				Black
2-(72 hours after death with the Maryland Insturet; or Items 23s or 28e-f show dical Execulturer; sust be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occupa kind of work done of	during most of worl	king	16b. Kind of Business	Industry
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b	be filed tal Hygi d other event, I	Be (17. Father's Name (First, Middle, La	st)	Unknown	n	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
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Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Marylan It and Marylan It and Marylan It and Marylan 71s marked ther then "naturel; or liems 23a or 28e-f show treumatic event, it a Marical Executive roust to notified at	ľ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 i		Rev. Bessie S	pence-Fri	end 4516	6 Old Co	ourt Roa	ad, Pik	esville,	Md 21208
ē,			20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place		Date	20c. Location - City or	Town, State
Baltimore,	permit. Pages Department of I Important: If It any injury or o		1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		1	•		2/06	Randallst	own, Md
₩	artm orta inju		21. Signature of Funeral Service Li			2. Name and Address arch F/H				
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			23a. Part1. Enter the disease, or o	emplications that cause	d the death. Do not ent					Approximate Interval Between
			shock, or heart failure. List or Immediate Cause (Final			-				Onset and Death
П	Physician /Medical		disease or condition resulting in death)	- But	ateral	Pheup	nonia			Z weeks
	Examiner	1		Dua to tot as	a consequence or,	1 .	4			7
		<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due o (o as	a consequence of):	etre	hila			Z weeks.
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<u> </u>		Completed						perfo	rmed? death? 2☑No 1☐Yes	2 □ No
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0			27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time o ay Year) Injury	of 28c. Injury Wor	y at k?	28d. Describe h	now injury occurred	
Ö	tttandin death. ctor: Af y the fur	atic	2 Accident investiga	tion		M 1 □	Yes 2 □No			
Division	or Attano after deatl Director: in by the	tific	3 Suicide 6 Could no 4 Homicide determin	200. Flace of III	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or R vn. State)	ural Route Number,
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	hour hour uner ly fill		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best caminer: On the basis of	of my knowledge, deat	th occurred at the tin	ne, date and place	, and due to the or	cause(s) and manner a	s stated. e to the cause(s)
	To the Hospitel or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	one) 29b. Signature and title of certifier	and manner s		29c. Licens			29d. Date signed (Mon	
	64€4		1	7		D.	-1720	2	4-27	- 2 n . /
	X.		20 Name and district	no completed 2	death (Item 33a) (Tuca	Print)	1120	4	1-21	-2006 1021222
	X		30. Name and address of person w	1 - L	CT. Lin :		VE	RAITI	MANDE N	11 7 17 7 7
		ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	- AMA	IVE,	$\nu r = 1$	1 JONE 1	12615-6
	Regist		MAY 0 3	A.	we B. A	calls				

			For St	ate of Maryland				-	•	Jie.
			1 - State Registrar	•	Certifica			•	Reg. No.	6 39 0
	Physici	an	1. Decedent's Name (First, Middle, Last)			2	1	2. Date of Dea	ath Day	3. Time of Death
	/Medi		John			DURG	ych	111.44		04 12:04 PM
7	Examir	er	4a. Facility Name (If not institution, give stree	t and number)	4b. Cit	y, Town, or I	Location of Death	/ /	4c. County	of Death
			5. Social Security Number 6. Sex	7. Age (In yrs. last	Al JO	er 1 Year	MOL S If Under 24 Hrs.	0. Data of Die		0.5:0.4
	Funeral Director		219-22-9890	2□ F 78	Yrs. Months		Hours Min.	8. Date of Birt (Month, Da) Feb. 29	y, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					reb. Z	,1920	Maryland
	anylan show	-	10a. State 10b. County		own or Location				· -	10d. Inside City Limits
	8a-f	cto	Maryland	ват	timore		***			XXYes 2 No
	with the Maryland a or 28a-f show Le notified at	Funeral Director	10e. Street and Number			ip Code			10g. Citizen of W	/hat Country?
	eath w	erai	3205 Harwell Avenue	Vas Decedent Ever in U.S.		1213	nania Osinia 2 /C-		U.S.A.	American Leiber
′0	riter d	퍒	Α	med Forces?	If Yes, sp	ecify Cuban	panic Origin? (Sp , Mexican, Puerto	Rican, etc.)	Blace	e - American Indian, k, White, etc.
03	72 hours after death with the Maryland natural", or items 23a or 28a-f show Iteal Examiliaer must be inclified ut	þ		Yes, Give 'ear or Dates:	1 🗆 Yes	2CXNo	Specify:		Specify.	White
21215-0036	72 hc	Completed	15. Decedent's Education (Specify only highest grade con	n 1	6a. Decedent's Us	ual Occupat	tion	ring	16b. Kind of Bu	siness/Industry
121	within ene. then	m	Elementary/Secondary (0-12)	college (1-4or 5+)			iring most of work	9	_	
		ပိ	8th grade 17. Father's Name (First, Middle, Last)		Lithogra		18. Mother's Nam	o (Fired Adiabate	Can Com	* *
ano	d ta b e	To Be	John Francis Burdych	s. Sr.		1	Mary Sl		maiden Sumami	3)
Maryland	should by nd Menta marked	Ě	19a. Informant's Name/Relationship (Type, F		9b. Mailing Addres				r. City or Town.	State, Zin Code)
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Constance Burdych /		3205 Har					213
Baltimore,	of Hea of Hea fitem rothe		20a. Method of Disposition	20b. Place	of Disposition (Natery, crematory or	ame of other place)	Date	20c. Location - 0	City or Town, State
<u>Ĕ</u>	Pages tment of tant: If it		1 X Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	variioni State	Stanisla	us Cen	n. 05-04		Baltimo	
3alt	permit. Departi Importi any inj		21. Signature of Filner Service Licensee							eral Home, Inc.
	00 = e 0		John ams	>			Road,			land 21206
	Pnysician /Medical Examiner	J.	23a. Pan/. Enter the disease, or complication shock, or hearn ailure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leaders to immediate	use on each line. At a consequence of the conseque	Failu			or respiratory an	os.,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence						4 days
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900	as ber 2 sho	plet	Myasthemia BR	AUIS				24a. Was a		ere autopsy findings available
	The law cate has page 2	E O						autops perfor	med? de	rior to completion of cause of eath? □ Yes 2□ No
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat			
of Vital	shys this	P	1 ☐ Yes 2 ☐ No Hospit	1 Lipropatient 2 LERV	Outpatient 3 D	-	4 Nuising no		ence 6 Othe	
on C	ding F h. After funera	ion		a. Date of Injury (Month, Day Year) 28b	o. Time of Injury M	28c. Injury a Work?		28d. Describe h	ow injury occurre	d
Division	Attending r death. ector: After oy the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28	e. Place of Injury - At home,			s 2 No	28f. Location (S	treet and Numbe	r or Rural Route Number,
D.	alor/s after	erti	4 Homicide	building, etc. (Specify)		19, 011100		City or Towi	n, State)	or transfer route reamper,
NU	To the Hospital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical Certification:	(Check only 2 Medical Examinar: (r: To the best of my knowled on the basis of examination and manner stated.	lge, death occurred and/or investigation	d at the time n, in my opin	, date and place, nion, death occurr	and due to the coed at the time, d	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1	29	Oc. License r	number	2	9d. Date signed	(Month, Day, Year)
•	1		M. AN	0	C	000	55229	/	May 1	7001.
	V		30. Name and address of person who complete	ted cause of death (Item 23a	a) (Type, Print)	101	1 11-	440	1/1	1 2000
			Dr. Ench. Aldrich 31. Date filed (Month, Day, Year)	32. Registrar's Signature	H. WOIL	e of	194 HV	MULE, 1	UARY HA	10 418/
	Sta . Registr		MAY 0 3 2006	lesses so f	Grand .				•	

		1 - For State Registrar	State of Marylar		artment of Health a	and Mer		ne No.20	16	13911
Physi /Med	ician dical	Decedent's Name (First, Middle, Last)	James	Chr	stopher	2.	Date of Death Month	27 2	Yeer	3. Time of Death $5: 45AM$
Exam	niner	4a. Facility Name (If not institution, give start of the	Nursing Ce	nter last birthday)	4b. City, Town, or Location of Balt	7 mo (Date of Birth	4c. County o	no 9. Birthplac	ce (State or Foreign
Directo		201.09.5371	M 2□F	88 Yrs.	Months Days Hours		(Month, Day, Y August 8,		Country	⁄/ //aryland
and *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation		, lagact c,			I. Inside City Limits
Maryl:	ō		ward		Ellicott C	City				1 ☐ Yes 2 🙀 No
n the	Director	10e. Street and Number	ward		10f. Zip Code	, icy	10g	. Citizen of Wi	hat Country	n
23a c	<u>s</u>	3822 Spring Meadow C	ourt			042			U.S.A	
ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland ital hygiene. tal hygiene in natural, or items 23e or 28a-f ehow dother then "natural, or items 23e or 28a-f ehow event, it a Medical Exertine result be ricitlified at	by Funeral	11. Maritat Status 1 □ Never Married 2 □ Married 3 □ ₩idowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 ☐ Yes 2 ☐ No Specify:		y Yes or No- an, etc.)		- American , White, etc	
Z15-UU36 tithin 72 hours at se. ne. "natural", or	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) Cotlege (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during mos DO NOT use retired)	at of working	16	b. Kind of Bus	siness/Indu	*
illed with Hygiene. other ther	Com	12			Electric wiring s					
€ da B	Be	17. Father's Name (First, Middle, Last) Allen C	hristopher					LeCom	pt	
Aar 2 sho and 1s mu	4	19a. Informant's Name/Relationship (Ty			ng Address (Street and Number					
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic.		Mr. George Burgtorf 20a. Method of Disposition 1 Surial 2 Cremation 3 F	20b.	Place of Disp	3822 Spring Meadov osition (Name of matory or other place)	V Court E		Maryland c. Location - 0		
Pages ment of lant: If its		`4 □Donation 5 □Other (Specify)	1		aven Memorial Park		1/2006	Gl	en Burn	ie, MD
Baltimo	once.	21. Signature of Funeral Service Licen	le (Moss	2	2. Name and Address of Facili Slack Funera 3871 Old Col	l Home. I	P.A.	City MID (21042	
Physicia /Medica	_	23a. Part1. Enter the disease, or complete control of the complete control of the	ications that caused the deane cause on each line. Due to (or as a conse	Deme	ter the mode of dying, such as	cardiac or re	espiratory arresi	ony, 1410 2	l i	Approximate interval Between Driset and Death
Examine wuden	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	Sow	hagia ation in	<i>Eum</i> [‡]	onice		3	conths 3
68760, rificate be executed to physician and as the burial-transit	edical Ex		d	quentre oi).	V					
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of delivery th D	r day Year
rds, P quires that n signed b	à	Part II. Other significant conditions co	ntributing to death but not re n 九のり	sulting in the (underlying cause given in Part	l. 			bute to the	cause of death?
f Vital Records, ysician: The law requires t is certificate has been signe director, page 2 should be o	Completed	1					24a. Was an autopsy performe	24b. W pr do 2No 1	Vere autops rior to comp eath?	sy findings available bletion of cause of
Vital F ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Check only one)			
Of Physical this cal direction	<u>P</u>	1 Yes 2UTNO	1 ☐ Inpatient 2 ☐	28b. Time	IN 3 DOA 447		5 Residen			
Vision of Vita Attending Physician: r death. ector: After this certific by the funeral director.	flon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	of 28c. Injury at Work? M 1 □ Yes 2 □			, , ,		
5 5 E	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At building, etc. (Spec		treet, factory, office	281	t. Location (Stre City or Town,	et and Numbe State)	er or Rural i	Route Number,
Hospital 24 hours a Funeral I	Medical				th occurred at the time, date an investigation, in my opinion, dea					
To the within 2 to the Complet	2	29b. Signature and title of certifier	/>		29c. License number		290	d. Date signed	(Month, D	ay, Year)
4		· //m	W ms		7553	91	A	pril	27,	2006
5		30. Name and address of person who a	bmpleted cause of death (the	om 23a) (Type	, Print)	re	Mary	and.	212	27
	State	31. Date filed (Month, Pay, Year)	32. Registrar's Sign	nature	losso o					

			1 - For State Registrar	State of	of Marylar		artment of rtificate of				gien	. U U D	13912
	Physic	an	1. Decedent's Name (First, Mid-	dle, Last)						2. Date of De		Vooc Year	3. Time of Death
	/Medi		Ruth L. Co	mstock			,			April	28 2	2006 Year	1:10 P M
	Examir	er	4a. Facility Name (If not instituti	_			4b. City, Town,		of Oeath			County of Deatl	
			Franklinwoods				Rossvi		0411-2			Baltimor	
	Funeral Director		5. Social Security Number 217 12 6420	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 82	Yrs.	Months Day		Min.	8. Date of Bir (Month, Da FEDILLAIL)	th ay, Xear, ZO	1924 Phi 12	pplace (State or Foreign CEIPHIA, PA
	land		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
)	Maryi i •hc	ō	Maryland Baltin	20120	Bai	Ltimore (Country						1 ☐ Yes 2 ☑ No
•	28a	rect	Maryland Baltin 10e. Street and Number	DLE		LUIIDLE	10f. Zip Code				10g. Ci	tizen of What Co	
	3 or	Funeral Director	1418 Rosewick Awe	arn ie			21237				_	ISA	y.
	death ms 2:	era	11. Marital Status	12. Was Dec	edent Ever in U		Was Decedent of	Hispanic Ori	igin? (Spec	cify Yes or No		14. Race - Amer	ncan Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show with injury or other traumatic event, the Medical Examinar must be notified at Angle.	by	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes G	2 XNo		fYes, specify Cu 1 □ Yes 2 🔯 No	ban, Mexicar	n, Puerto R	Rican, etc.)		Specify: White	e, etc.
Ö	2 ho	Completed	15. Oecede	ent's Education		16a. Deced	dent's Usual Occi	upation			16b. K	(ind of Business/I	
216	thin 7	pje	(Specify only night Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)	life.	kind of work don DO NOT use retir	e during mos ed)	st of workin	g			·
	o d w	50	12	N/A	,	Inspec	tor				Prin	iting Indus	stry
Maryland	d oth	Be	17. Father's Name (First, Middle	a, Last)						(First, Middle,	, Maider	Sumame)	
<u>X</u>	Ment Ment arke	2	George M. Hofmann					Fona	E. Pet	ti.t			
a	2 sho and is m	0. 4	19a. Informant's Name/Relation	nship (Type, Print)								or Town, State, Z	ip Code)
	and ealth m 27		Janice Siebenhaar			1906	Dewbury I	rive B		and the same of th			
ore	Jes 1 of H if ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	State	cemetery, cren	sition (Name of natory or other pl	, ,	Da	ate		ocation - City or 1	
Ë	men men tant:		4 □Donation 5 □ Other	(Specify)	Gar	ndens of	Faith Cen	ı. May 1	L 2006		Balt	imore, Mary	yland
Baltimore,	Depermit Depermit Import		21. Signature of Funeral Service	e Licensee			Name and Add assahn fur 401 Jelair				vlami	21236	
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that	cabsed the deat	th. Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Enc	1 54	A00	E	Anne	000	1 14			Onset and Death
4	/Medical		resulting in death)	Due to	(or as a conseq	juence of):	VYVI	bunda	SCAA	111			
	Examiner		Sequentially list conditions.	b									
	p is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	juence of):							
	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	c	/								
60,	cien cien	E	•	Ode to	(or as a conseq	juence or):							
68760,	icate be executed physicien and the burial-transit	dicai		d				-					
_	ding se as	/Me	IF FEMALE:	23c If yes ou	tcome of pregna	ancy							
Вох	death certifii e attending p od for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live t	ointh 2 ☐ Feta nant at time of d	il death 3 □	Ectopic pregnand Other (specify)	су				23d. Date of delive Month	very Day Year
P.0.	0 0 2	Physician/Me	1 Yes 2 No 9 Unknown	9□ Unkn		5_	Coller (specify)						
	signed by d be deta	Ā	Part II. Other significant condit	ions contributing to d	eath but not res	ulting in the ur	nderlying cause g	ven in Part I.		23e. Did to	obacco i	use contribute to	the cause of death?
Records,	law requires that the es been signed by th 2 should be detache	d by								1 🗆 Y	res 2	□No 3 2 2 1 1 1	bably 4 Unknown
8	s been si should	Completed								24a. Was	an	24b. Were aut	opsy findings available
Re	hysicien: The lav his certificete hes I director, page 2 :	E									rmed?	prior to co	ompletion of cause of
Vital	en: tifice tor. p	0	25. Was case referred to medic	al				26 Place	of Death	1 ☐ Yes (Check only o	2 No	1 🗆 Yes	2 No
Ξ	Physicien: this certifice ral director.	To B	examiner? 1 ∐ Yes 2∰2No	Hospital:	Inpatient 2	ER/Outpatien	3 □ DOA O					6 □Other (Speci	6.1
o t	g Ph ter th		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of	28c. Inju			d. Describe h			197
Ö	ath. or: Afr	atio	- C114000011	tigation	in, Day rear)	Injury]Yes 2 ☐1	No				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 288. Place	of Injury - At he	ome, farm, stre	et, factory, office		28	If. Location (S City or Tou	Street an	d Number or Rur	al Route Number,
	ital o irs eff rai Di lled ir												
	To the Hospital or Attending Physical within 24 hours eiter death. To the Funeral Director: After this completely filled in by the funeral directors.	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the b I Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, an th occurred	nd due to the o	cause(s) date and	and manner as s diplace, and due t	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifi	er		-	29c. Licer	se number		-	29d. Da	te signed (Month,	Day, Year)
,	9		1 De	-			7	>53ci	67			1/2910	6
1	0		30. Name and address of person	who completed caus	e of death (Item	n 23a) (Type, I	Print) J	ude	W	Juese	2	an.	
_ ~					bad	6len	Burni	emp	> 6	31061			
	Sta		31. Date filed (Month, Day, Year	No.	legistrar's Signa	iture	00.80						
	Registr	ar	MAY 0	3 2006	6005 0 B	4 600	W.						

			1 - For State Registrar	State of M	arylan		ertment of H tificate of I	lealth and M Death		ene	6	3913
	Physici	an	1. Decedent's Name (First, Middle, Last)		G.		Clemor		2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	Aretha 4a. Facility Name (If not institution, give	atract and aumhori	٠.			Location of Death	4	22	2006 y of Death	8:15a ^M
	Examin	er	2209 E. 30th St					imore		4c. Count	NA	
	Funeral		5. Social Security Number 6. Sec	7. Ag		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear)	9. Birthpla	ace (State or Foreign
ia Sa	Director		251-42-7837 Usual Residence of Decedent	M 2[XF	85	Yrs.	Wielling Bays	110010	12-3-2	20		" S.C.
	/land		10a. State 10b. County		10c. City	y, Town or Lo	cation				10	d. Inside City Limits
	a-f sh	tor	Md. NA			Balt	imore					Y☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code		100		What Count	ry?
	death with the Maryland rms 23a or 28a-f show	Funeral I	2009 E. 30th Stre	12. Was Decedent	Ever in III	S 13 V	212		acifu Vas as No		SA ce - America	n Indian
0	r item	Fun	1 ☐ Never Married 2 ☐ Marned	Armed Forces? 1 ☐ Yes 2 🔀		l II		spanic Origin? (Spanic American, Puerto	Rican, etc.)		ick, White, e	
3-003d	ral', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2X No	Specify:		Speci	^{fy:} Bl	.ack
ה	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		16a. Deced	ent's Usual Occupa	ation during most of work ()	ing 16	6b. Kind of 8	Business/Indu	istry
7	withir lene. than	omo	Elementary/Secondary (0-12)	College (1-4or	5+)		ustodian	,		J.H.	Unive	rsity
ם ס	other	Be C	6th grade 17. Father's Name (First, Middle, Last)			l 		18. Mother's Name	e (First, Middle, Ma	aiden Suma		
yland	2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or its aumatic event, Ira M. dical Examina	ToE	Henry			Green		Fannie			Conn	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show eny Injury or other traumatic event, the Modical Examinar must be notified at one.		19a. Informant's Name/Relationship (Ty Ernestine Clemons		ghter			n Street,				218
ore,	ges 1 a t of He if Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	Cé	emetery, crem	sition (Name of natory or other place	θ)			- City or Tow	
pairimor	it. Paritmen intent: njury		4 Deceation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	- / -	Ga		Forest \	/et. Cem.	5-2-06 Baltimo			ls, Md.
D D	Depar Impo eny Ir		and of	11/2 Otto	I		March F.I	·	1101 E			
			23a. Part1/ Enter the disease, or complete shock, or heart failure. List only or	ications that caused	the eath	*						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			vasi	vlar	Colla	oses			3 hours
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):						- ///
ı.	4 %	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):						
/	ficate be executed physician and s the burial-transit	Examiner	that initiated events	;								
Š	oe exe cian ar urial-t		resulting in death) Last	Due to (or as	a consequ	uence of):						
28/20	physic physic the b	dical		j								
ZOZ C	nding use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregna					23d. Da	ate of deliver	y
Ď	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)			М	onth [Day Year
<u>ر</u>	hat the d by ti	by Phys	9 ☐ Unknown Part II. Other significent conditions con		ut not resu	uting in the un	dorhing cause aure	on in Part I	23e Did toba	CCO USA COO	tribute to the	cause of death?
necords,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit			ellitus	2	and the dis	denying cause give	or in react.		2 🗆 No	3 Proba	/
င္သ	law reas bee	Completed	Hypertension	1					24a. Was an autopsy	24b.	Were autops	sy findings available pletion of cause of
		Con	Hyperlipiden	nia					performe	No No	death? 1 ☐ Yes 2	
Vilai	Physician: this certific rat director,	Be	25. Was dase referred to medical examiner?	lospital:			Othe		(Check only one)			
ō	Phys er this erat di	2	1 Yes 2 No	28a. Date of Inju	iry	ER/Outpatient 28b. Time of	28c. Injury Work	4 Nursing no	me 5 Resident 28d. Describe how			
0	ath. or: Afte	atio	1	(Month, Da	y rear)	Injury		Yes 2 □ No				
JIVISION OF	To the Hospital or Attending Physic within 24 hours efter death. To the Funaral Director: After this ce completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specify</i>	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,		ber or Rural	Route Number,
_	spital hours naral / filled		29a. Certifier Certifying Phys	sician: To the best	of my know	wledge, death	occurred at the tim	ne, date and place,	and due to the cau	se(s) and m	anner as sta	ted.
	the Ho lin 24 the Fu pletel	Medical	(Check only 2 Medical Examination)	ner: On the basis o and manner st	f examinat ated.	tion and/or inv			ed at the time, date	e and place,	and due to t	he cause(s)
	To To	2	29b. Signature and tale of certifier	0 01	^	\	29c. License			_	ed (Month, D	
	2		30. Name and address of person who co	LLUYUU	leath (Item	23a) (Type	Print)	, , , , , , , , , , , , , , , , , , , ,		May	1 4 2	,006
)		SIMUN DITT	LLON	N.L	0.	3333 /	V. CALV	enr s	T.	SUIT	き 555.
	Sta		31. Date filed (Month, Day, Year)	/32. Registr	ar's Signal	ture	20					
- L	Registr	ar	MAY 0 3 2006	and the second	63.64	20						

			1 - For State Registrar	-		nd / Depa	artment of his	lealth a	and M	lental Hy) 6	3915
	Dhusisi		Decedent's Name (First, Middle, La							2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		BETTY JANE	COGR	JRN					MALL	28	2506	7-35 AM
	Examin		4a. Facifity Name (If not institution, give				4b. City, Town, o		of Death			nty of Death	
	*		LAVREZ REZISMA					REZ				NE 46	2012 52
	Funeral Director			M 2∏F	7, Age (In yrs. 82	last birthday) Yrs.	Months Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) Feb 12,	1924	9. Birthpi Coun Tenr	lace (State or Foreign try) 1essee
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					11	0d. Inside City Limits
	hours after death with the Maryland turel', or items 23a or 28a-f ehow at Examiner must be mailited at	ro	Maryland Anne Ar	ındel	La	urel							1 □Yes 2□No
	28a	rec	10e. Street and Number	anacı	Ба	urer	10f. Zip Code				10g. Citizen o	of What Coun	
	3a o	Funeral Director	3563 Fort Meade R	oad #62	4		20724	1			USA		
	death	nera	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.	Was Decedent of H	lispanic Orig	gin? (Spe	ecify Yes or No-	14. R	ace - Americ	
٥	after or ite	Fu	1XXNever Married 2 ☐ Married	Armed For 1 Tes If Yes, Give	2 XX No				i, Puerto	Hican, etc.)		lack, White,	
3	ours irai', LExa	d by	3 Widowed 4 Divorced	Year or Da	tes:		1 ☐ Yes 2 🗓 🌿	Specify:			Spec	eity: Whi	te
212-0036	72 h "natu	ete	15. Decedent's E (Specify only highest gra	ducation de completed)		(Give	dent's Usual Occup kind of work done	during most	t of worki	ng	16b. Kind of	Business/Ind	lustry
717	within 72 hours after death with the Marylan jiene. r than "natural", or items 23a or 28a-f ehow the Mcdical Examinat must be mutified at	Completed	Efementary/Secondary (0-12) Grade 12	College (1-	4or 5+)		<i>00 NOT use retire</i> naker	<i>a)</i>			Own H	ome	
	Hys Hys ort,	ပိ	17. Father's Name (First, Middle, Last,					18. Mothe	r's Name	(First, Middle,			
yland	Q 20 D	To Be	Thomas Baugh					Grac	e Pe	ttit		,	
_	should ind Men s marka umatic	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rura	l Route Numbe	r, City or Tow	m, State, Zip	Code)
Mai	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Carol Stirn /	daugh	ter	7425	Village	Road	#4	Sykesv	ille,	MD 21	784
9	es 1 and of Heall fitem 2 r other		20a. Method of Disposition 1 ☐ Buriaf 2 ☐ Germation 3 ☐	Damaual from C	20b.	Place of Dispo	sition (Name of natory or other place	ce)	С	Date	20c. Location	n - City or To	wn, State
Ĕ	Pagement ant: i		4 □ Donation 5 □ Other (Specif		late		ndel Crem		5/2/	2006	Odent	on, Ma	ryland
baitimore	permit. Pages to Department of Findourtent: if ite any Injury or ot once.		21. Signature of Funeral Service Licer	1500		22	Name and Addre	ss of Facility	ral	Home, P	.A.		
_	₹0.5 € Ø		148 SER		/ M007	70	313 Talbo	tt Av	enue	Laure	l, Mar	yland	20707
	7		23a. Part1. Enter the disease, or com shock, or heart failure. List only	pfications that ca one cause on ea	used the dea ch fine.	th. Do not ent	er the mode of dyir	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				LLVER	CAN	SCE	R			Onsor and Doam
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last										
ĵ	ate be executed hysician end ihe burial-transit		resulting in death) Last	Due to (c	r as a consec	quence of):							
6/00,	certificate be executed Iding physician end Ise as the burial-transit	licai	•	d			· · ·						
Ď ×	ertific Jing p	Mec	IF FEMALE:	02- 11									
XOD	death c	lan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No		th 2 □ Feta ntattime of c	al death 3	Ectopic pregnancy Other (specify)	,				ate of deliver Month	ry Day Year
j	w requires that the death certifica been signed by the attending ph should be detached for use as it	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknov		104III 3 L	Other (specify) _						
7	s that	by Pr	Part II. Other significant conditions of	ontributing to dea	ith but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use co	ntribute to the	e cause of death?
splosa	quire en sig		IFBRATIC CON	MA						1 🗆 Y	es 20 No	3 🗌 Proba	abfy 4 Unknown
ည သ	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	Completed								24a. Was a		. Were autop	sy findings available
Č	The ate ha	E O								perfor		death?	npletion of cause of 250No
1121	clan: ertific ector,	Be (25. Was case referred to medical examiner?							(Check only or	16)		
5	Physic this c	ပ	1 Yes 2 No			ER/Outpatien	t 3 DOA Oth	er: 4□Nur		ne 5 🗆 Resid)
	ding F	ion	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of (Month	Day Year)	28b. Time of Injury	28c. fnjur Wor			28d. Describe h	ow intury occi	urred	
VISION	death death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not b	.	of Injury - At h	ome farm str	et, factory, office	Yes 2 N		28f. Location (S	treet and Nur	nhar or Rural	Pouts Number
2	after after Dire	Certification;	4 Homicide determined	buildin	g, etc. (Specia	(y)	out, ractory, office			City or Tow		noor or ridrar	riodia ivanibal,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has scomplately filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician; To the to niner; On the base and manner	sis of examina	owledge, death	occurred at the tin restigation, in my o	ne, date and pinion, deat	d place, a	and due to the ded at the time, o	ause(s) and r late and place	nanner as sta	ated. the cause(s)
	o the o the ompla	Mec	29b. Signature and title of certifier	ano mailne	. 3(2(6)).		29c. Licens	e number		- 2	9d. Date sign	ned (Month, E	Pay, Year)
	o de e		> Demel	lyang.	~~		D 3	6970	+		4/20		
	1		30. Name and address of person who				•	r Ent	V 40	(r > -0.2			mo 21544
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2006		gistrar's Signa		الم	CONT	rmu	CAPT 4	الماليل فعي	VVG IT	· out or oth
100	100	No.	MITTI V 3 2000	1 6 0 0000	and the same	100							

			State Registrar	State of Man	yland		artment rtificate			and M	-	giene Reg. No.	UUU	13916
	Physici /Medic		 Decedent's Name (First, Middle, Last) Melvin Duckett, 	Jr.							2. Date of De. Month May	Day	y Year	3. Time of Death 10:53 A. M
	Examin		4a. Facility Name (If not institution, give s 5 Montrose Avenu						Location o				County of Deat	h imore
	Funeral Director		216-24-8989	7. Age (I	In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	Min.	8. Date of Bird (Month, Da Feb. 3	v. Year)	9. Bin Co 28 Mar	hplace (State or Foreign buntry) yland
	ith the Maryland or 28a-1 show	ctor	Usual Residence of Decedent			Town or Lo								10d. Inside City Limits 1 ☐ Yes 23 No
	uth with th 23a or 26 unt be no	i Dire	10e. Street and Number 5 Montrose Avenue	2			10f. Zip	Code 212:	28			10g. Citi	izen of What Co A	ountry?
036	or items	by Funeral Director		12. Was Decedent Eve Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	er in U.S		Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit Specify: WI	
21215-0036	filed within 72 hours Hygiene. Ither then "natural", ont, the Wedical Ex.	Be Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)		(Give life.	dent's Usua kind of wor DO NOT us	k done d e retired)	tion uring most	t of worki	ng		nd of Business/	
Maryland 2	ould be filed within Mental Hygiene. arked other theretic event, the Mentic event, the Mentic event.	To Be Co	12 17. Father's Name (First, Middle, Last) Melvin Duckett, Si	·		Self	Emp1				(First, Middle, Dusterh	Maiden		Produce
	nd 2 should be lith and Mental 27 is marked (r traumatic ev		19a. Informant's Name/Relationship (Ty, Margaret Rose Dat										r Town, State, 2	
Baltimore,	Pages 1 and 2 nent of Heath a int: If item 27 is iry or other trai		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		ce	ace of Dispo metery, crer	natory or ot	her place			006		cation - City or	Town, State Maryland
Balti	permit. Pages Department of I Important: If ite eny injury or of		21. Signature of Funeral Service License	Selve	sle	1) 22	. Name and Funera	Addres	s of Facility	Ster f Ca	ling Astonsvil	hto:	n Schwal	MD 21228
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that ceused the cause on each line.	e death.						r respiratory ar		sville,	Approximate Interval Between Onset and Death Proximate
760,1	e be executed /sician and e purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a c	consequ	ence of): HMS ence of):	tic	VC	rsci	ila	rv d.	i'se	ase	5 years
P.O. Box 6	Attending Physicien: The law requires that the death certifical croadh. croadh. ector: Alther this certificale has been signed by the atlending phy ector. page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of a 1 live birth 2 live birth 2 live birth 2 live gnant at time 9 live Unknown	Fetal	death 3	Ectopic pre		-			2	23d. Date of del Month	ivery Day Year
rds, P.	w requires that the been signed by should be detact	by	Part II. Other significant conditions cor	etributing to death but r	not resu	lting in the u	nderlying ca	iuse give	n in Part I.				se contribute to	the cause of death?
Division of Vital Records,	The law requate has been page 2 should	Completed									24a. Was autop perfo 1 Yes		24b. Were au prior to death?	topsy findings available completion of cause of
Vita	ysicien: The I	Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient	م ا	ER/Outpatien		Othe			(Check only o			
ion of	nding Phys tth. :: After this e funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		28b. Time of Injury		Bc. Injury Work	4 140	2	28d. Describe h		5 □Other (Spec y occurred	city)
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At hor Specify;	me, farm, str	eet, factory,	office		2	28f. Location (5 City or Tox			ral Route Number,
	ne Hospit n 24 hours ne Funere	edical (29a. Certifier (Check only one) 15d Certifying Phys	sician: To the best of n ner: On the basis of ex and manner stated	caminati	vledge, death ion and/or in	occurred a vestigation,	it the time in my op	e, date and inion, deat	d place, a	and due to the ded at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
		M	29b. Signature and title of certifier	Inega	n	MO	29c.	License - 00	-	73		29d. Dat	e signed (Monti	n, Day, Year)
	20		30. Name and address of person who co Dr. Laura Donega				Print) 6701	N. C	har1	es Si	. To	wson	MD 212	04
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2006	2. Registrar's			K							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of		id Mental F		2006	1391
Physici edical Exami		Decedent's Name (First, Middle,Last) ROBERT LOUIS DARLING			2. Date of Deat	h	3. Time of Death
		TOPINI BOOLD DIRECTIO	b. City, Town, or	Location of Deat	Month April 14, 2	4c. County of Deatl	1637 hrs
		917 Philip Powers Drive	Laurel			Prince George	e's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs last birthday)	If Under 1 Year Months Day			th(MM/DD/YYYY) 9. Bir Foreig	an
Director		216-34-0368 1 M 2 F 68 Yrs.			May 1	, 1937 Co	ountry) Maryland
any		10a State 10b. County 10c. City, Town or Location	n				10d Inside City Limits
<u> </u>	'n	Maryland Prince George's Laurel					1 XXYes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Cou	ntry?
vith the Maryland \$ 23a or 28a-f shov : notified at once.		917 Philip Powers Drive	20707			U.S.A.	
5-0036 led within 72 hours after death with the Maryland tygene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	uneral	1 Never Married 2 y Married Armed Forces? If Ye	Decedent of His s, specify Cubar	spanic Origin? (S n, Mexican, Puerti	pecify Yes or No- o Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
fter de	ш	1 Yes 2 XX No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 XXNo				• •
ours a	d by	15. Decedent's Education (Specify only highest grade completed) 16a Decedent's	s Usual Occupa	tion (Give kind of	work done	16b. Kind of Business/	ite Industry
36 n 72 h nan "n ical E	olete	College (1-4 or 5+)	ŭ	DO NOT use rei	tired)		
5-0036 led within 72 hours after Hygiene other than "natural"; the Medical Examiner	Completed	Grade 12 Driver 17 Father's Name (First, Middle, Last)	/ Body		o /Eurot Middle A	Maryland Maiden Surname)	Jockey Club
21 De fil Ital I Iked	Be	Lewis Darling			ne Cochi		
D 21 should be and Mer 7 is mar	ပို	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Stree			ber, City or Town, State	, Zip Code)
Z dath alth		Ah-Hoe (Florence) Teo / spouse 917 P 20a Method of Disposition 20b Place of Dispositi				rel, Maryl	
는 se 는 필		1 XXBurial 2 Cremation 3 Removal from State crematory or other	er place)		Date (2.0.0.6	20c. Location - City or	
Baltimore, permit Pages a Department of He Important: If ite		4 Donation 5 Other Specify: Meadowridg 21 Signature of Europy Service Licensee 22 Na			26/2006	Dorsey, M	aryland ———
Dep Imp		/ W00770 DO	naldson 3 Talbo	Tuneral tt Avenu	Home, F	P.A. el, Marylan	d 20707
Physician /Medical		23a. Part I. En. r the disease, or p implications that caused the death. Do not enter the failure. List only one cause in each line.	mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)					Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b					
	niner	if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause					
ed 🔏	Examiner	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of)					
760, ficate be executed g physician and the burial - transit	/Medical	d. UNPENDED AMENDED					
760, Treate be physicia the buria		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the				23d. Date of delivery	-
x 68	cian	past 12 months? 2 Feta	of (Specify)	Ectopic pregn	ancy	Month D	Day Year
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it	Physician	1 Yes 2 No 9 Unknown 9 Unknown					
cords, P.O. law requires that the has been signed by 2 should be detach.	by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause g	given in Part I.		bacco use contribute to	
ds, lequires	ted		<u> </u>		24a. Was a	2 No 3 Prob	topsy findings available
COF law r has b e 2 sh	Completed				autops perfor	y prior to c	ompletion of cause of
of Vital Records, ug Physiciau: The law requir the this certificate has been si neral director, page 2 should b		25. Was case referred to medical	26 Plans	of Death (Check	1 ✓ Yes 2		s 2 No
Vita ysician his cer directe	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		Other -		Residence 6 🗸 Other	Scene
n of Vital Rec liug Physiciau: The After this certificate funeral director, page	Ë	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	ury 28c. Inju	ry at Work?	28d. Describe h	ow injury occurred	
	atio	2 Accident Investigation Apr 14, 2006 1622 hrs		res 2 ✔ No	Subject shot	Self	
Division of Vital I To the Hospital or Attending Physiciau: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification	3 ✓ Suicide 6 Could not be determined (Specify) Sidewalk	factory, office b	_	or Town. St	treet and Number or Ru ate)	
Hospit 24 hour Funer rely fill		29a Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred	ed at the time, da			owers Drive, Laure	
To the Ho within 24 F To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated	n, in my opinion	, death occurred	at the time, date a	ind place, and due to the	au. cause(s)
- 2 - 0	ž	29b Signature and title of certifier	29c. Licens	e number		29d. Date signed (Mor	ith, Day, Year)
		my on mo	0.0.1	M.E.		April 15, 2006	
10		Name and address of person who completed cause of death (Item 23a) Ling Li, MD	Baltimore	MD 21201			
\ St	ate		M =				
Regist	trar	MAY 0 3 2006 States A					

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** April 26, 2006 6:45 P.M Doris Eichhorn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Timoníum If Under 1 Year II Under 24 Hrs. 8. Date of Birth
Months Dave Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Yrs. Director 1924 Maryland 217-12-3661 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28e-1 show other treumatic event, the Medical Examinar must be notified at 1X Yes 2 No Baltimore Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA 3379 St. Benedict Street death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No δ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working filed within Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil I Health and Mental H tem 27 is marked ott Be Marie B. Carle Vernon A. Burk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other treu 1500 Regester Avenue; Baltimore, MD 21229 John Eichhorn Son timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 4/29/06 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fyneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 mgms Sto ge months **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2- No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) δ 4 Homicide within 24 hours a To the Funerel C completely filled La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 5 5 2006 VIDI - meome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM21093 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19aperFH C855 5/3/06 TT Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** HIXI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) bhos Horkins Bayview Medical Center
5. Social Security Number 6. Sex 7 Age (1917) Examiner NA HIMOVE If Under 24 Hrs. 5. Social Security 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F Yrs. Director 212-44-8348 5-28-46 Mo Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow r than "natural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at 1 XYes 2 No Director NA Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21213 1841 N. Collington Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. e filed within 72 hours after in Hyglene.

Other than "natural", or Ite. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping 12th grade permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if Item 27 is marked other
eny Injury or other traum.... 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ireland Dozier Grace Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3311 Parklawn Avenue, Baltimore, Md. 21213 19a. In Dorol S Name (Relationship (Type, Print) Daughter Doorthea English 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-4-06 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. adr 1101 E. North Ave. March F.H. East war 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Human Immunodeficiency Virus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No
9 Unknown Year jo Month 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown certificate has been si rector, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 | Homicide within 24 hours af To the Funers! D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe Eliphet amfanepa, Medical Doctor April, 26, 2006 8

Registrar DHMH 17 Rev 1/2001

State

Assis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAY 0 3 2006

Elizabeth Anne Canepa, 4940 Eastern Avenue, Baltimare, Maryland, 21224 32 Registrar's Signature

Bet Sul

State of Maryland / Department of Health and Mental Hygierie 🗎 🧎 🧲 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4:52 AM (TLORIA FLOYD APRIL 30 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HARBOR BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M XXF 80 Yrs 214-24-2752 Director 09/26/1925 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits in then "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at MD N/A BALTIMORE CITY XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3510 ROUND ROAD 21225 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: BLACK 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CATERING FOOD SERVICE 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumatic event pose. Be ERNEST ROBINSON MAMIE LEE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4234 HUNTSHIRE RD, RANDALLSTOWN, MD Date Date 20c. Location - City or Town, Slate CHRYSTAL JOHNSON / NIECE MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 5/3/06 CATONSVILLE, MD 22. Name and Address of FacilityHOWELL FUNERAL HOME 21207 21. Signature 4600 LIBERTY HEIGHTS AV A Constitutions that daused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. 4600 LIBERTY HEIGHTS AVE., BALTIMORE, Approximate Interval Between Onset and Death Immediate Cause (Final disease de condition SEVERE SEPSIS **Physician** 2 DAT S /Medical resulting in death) Due to (or as a consequence of): Examiner MULTI ORGAN FAILURE 2 000 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner inding physicien and use as the burial-transit Attending Physician: The law requires that the death certificate be executed ORONAR DISEASE MANY YEAR RTERY that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 ATRIAL FIBRILLATION 2 DAYS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown H (PERTEN SION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ASTHMA 24a. Was an page 2 autopsy performed? 1 Yes 2/2 No director. 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 11 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☐ No After the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No To the Hospitei or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Indomune, RESODO APRIL 30 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH HANDVER ST, INDAHTUNG 3001 BALTMORE 31. Date filed (Month, Day, Year) MAY 0 3 2006 32. Registrar's Signature State Carles Registrar

		1 - State Registrar Amend #20b& 1. Decedent's Name (First, Middle, Last)	с гег гн доз4	2/03/06°3	m	2. Date of Deat		3. Time of Death
Physici	_	Zelma Marie	Harver			APRIL	30 200 e	- E 1/C 1
/Medic Examir	_	4a. Facility Name (If not institution, give: St. Agnes I+	street and number)	4b. Ci	ty, Town, or Location of De Baltunor	ath	4c. County of Dea	ath
Funeral Director		5. Social Security Number 6. Set 1 Supplies 1 Security Number 6. Set 1 Supplies 1 Suppli	7. Age (in yrs.	last birthday) If Und Month	der i Year If Under 24 H is Days Hours M	8. Date of Birth (Month, Day,	Year) 9. 8i	rthplace (State or Fore, ountry)
28a-f show	7	10a. State 10b. County		ty, Town or Location				10d. Inside City Lim 1 ☐ Yes 2 🔀 i
r 28a-f shov rotified at	ect	MD Balt ma	re co	tonoville	Zip Code	11	og. Citizen of What C	Country?
	Funeral Director	5946 St. Marys	Ci		21307		USA	,
items 23	era		12. Was Decedent Ever in U	I.S. 13. Was De	cedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Am	
5 🗟	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		pecify Cuban, Mexican, Pu : 2國 No Specify:	lerto Hican, etc.)	Specify:	ite, etc.
natur lica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed)	16a. Decedent's U (Give kind of life. DO NOT	sual Occupation work done during most of t Tuse retired)	working	16b. Kind of Business	s/Industry
giene. r than " It's Mes	mo	12th Grade	College (1-4or 5+)	Coregiv	er	`	Health C	are
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nd Menta marked imatic sv	Tof	Contad Hollac	ay		Lydi	e House	ard	
alith a 27 is r trait		19a. Informant's Name/Relationship (Ty Dr. Alicia B. Hary	rev-Smith	5946 9	ess (Street and Number or J. Marys S	CALL		
0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Place of Disposition (f	Centiliace) 5/0	Date 02/06 5- るととも	20c. Location - City o	wn.M1
Department of Important: If sny injury or pnce.		21. Signature of Funeral Service Licens	ee	22. Name	and Address of Facility	o Funetal	Service	1, 112
Pep eng eng		Youghn C	Greene	515	Balto, Nat	I. Pike Bo	alto, MD &	PEE18
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or		th. Do not enter the m	ode of dying, such as card	liac or respiratory arre	est,	Approximate Interval Between
nysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	Aortic A	1			onset and Death
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o Due to (or as a consec	quence of).				
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r death. ector: After this certificate hes been signed by the attending phy by the funeral director, page 2 should be detached for use as th	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 ryonths? 1 □ Yes 2 ☑ No 9 □ Unknown	l3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 ⊟Ectopio	c pregnancy (specify)		23d. Date of do Month	elivery Day Year
signed by	d by Ph	Part II. Other significant conditions con Pulse len electric	ntributing to death but not res	- 4	g cause given in Part I.	23e. Did tob	/	to the cause of death
sate hes been si page 2 should	mplete	Acute Renal 1				24a. Was a autops	24b. Were a prior to death?	autopsy findings avail completion of cause
certificete rector, pag		preumana				1□ Yes 2	PMo 1 □ Ye	
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h. After this funeral di	ion; To	27. Manner of Death 1 Death 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		w injury occurred	өспу)
i Sir	Certification;	2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fac		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
24 hours a Funeral I	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best of my knoner: On the basis of examinating and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plion, in my opinion, death o	ace, and due to the ca ccurred at the time, da	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	Me	29b. Signature and title of certifier	Julio MD		29c. License number	2	9d. Date signed (Mor	nth, Day, Year)
within 2 To the complet		100/	THE WIND		D10112		ADRII 2	2 9 ART
within 7 To the comple		30. Name and address of person who or			P18612 res Harpital		MINIT 3	0, 2006

DHMH 17 Rev 1/2001

HARVEY, ZELMA M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

X1X Yes 2 No

MARYLAND

WHITE

COMPANY

3:05 А. м

Yeer

U. S. A.

Specify:

14. Race - American Indian,

Black, White, etc.

BALTIMORE

^{Day} 2006 Physician MARY JANE HUGHES MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE, GILCHRIST CENTER TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-29-1946 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X X Days Hours 59 218-46-4767 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 'natural', or items 23a or 28a-f show liner class be notified at MD. N/A BALTIMORE CITY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3938 HICKORY **AVENUE** 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status X1X Never Married 2 Married 1 ☐ Yes XX No The Mudical Exam þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) AJILAN ADMINISTRATIVE ASSISTANT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any lighty or other traumatic event 900g. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NOBLE CALEB HUGHES MARIE ANNA SCHIESSER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN M.PRIMROSE (NIECE) 2011 COLGATE CIRCLE, FOREST HILL, MARYLAND, 21050 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee R. S. Ru (R. G. RUTH) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brust Physician Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rigury that initiated events resulting in death) Last Directo (or as a nonsequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 🗌 Yes Completed 24a Wasan certificate 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Yes 2 No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Pis After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 4 | Homicide

HILLTOP SERVICE CORP. 05-09-2006 TOWSON, MARYLAND, 21204 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 **Approximate** Onset and Death Years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics To the Hospital or Attending Plewithin 24 hours after death.
To the Funeral Director: After the Completely filled in by the funeral 28d. Describe how injury occurred Certification; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1.2006 58303 MAY 6401 N. CHARLES STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1 - For State Registrar

31. Date filed (Month, Day, Year)

CHANIES, MO

MAY 0 3 2006

HYLLEN.

TOWSON MD

		-	For State Registrar	State of Marylar	-	nt of Health and te of Death		ene 006	13923
	Physicia		1. Decedent's Name (First, Middle, Las	st)	Hidean		2. Date of Death	Pay 2 mYeer	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	e street and number)	HUDSON	y, Town, or Location of Deat	ran	46. County of Death	7:03 7,
	Examin	CI I	Baltimore Wash	nimiton media	al Center G	len Burn	ire ~	anne	arundel
	Funeral Director		5. Social Security Number 6. S 215-66-076	Sex 7. Age (In yrs.	/ Yrs. If Und Months	er 1 Year If Under 24 Hrs S Days Hours Min.		9. Birth	place (State or Foreign
	show	'n	Usual Residence of Decedent 10a. State 10b. County	An	ty, Town or Location	Pap V			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number	TON RO	15. 2	ip Code 7 1 1 1 1 / a	10	og. Citizen of What Cou	ntry?
8	ms 23	eral	11. Marital Status	12. Was Decedent Ever in t	J.S. 13. Was Dec	edent of Hispanic Origin? (Secrity Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ameri	can Indian,
0 €∩ -0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other treumatic svent, the Medical Examiner must be notified at 2008.	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		2 No Specity:	to Hican, etc.)	Specify: BA	ack
5.0	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		vork done during most of wo	rking	16b. Kind of Business/Ir	dustry
Vi 21215	ed within rgiene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Hausp	VIFE		HOME	
Hudson Baltimore, Maryland	is 1 and 2 should be filed within the thath and Mental Hygiene. Itam 27 is marked other than other treumatic svent, the Mental that the treumatic svent, the Mental that the treumatic svent.	To Be	17. Father's Name (First, Middle, Last) LEANDER PE	AMON		18. Mother's Na	me (First, Middle, M	Aaiden Sumame)	
Hudsor ore, Marylan	nd 2 sho alth and 1 27 is ma ir treums		19a. Informant's Name/Relationship (Type, Pript) Di 19UDSAN	19b. Mailing Addre	ss (Street and Number or R	ural Route Number, Pj. GEVER	City or Town, State, Zi	170,21146
式 g	Pages 1 a nent of Hea nut: If Itam ury or othe		20a. Vethod of Disposition ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposition (N cemetery, crematory o	ame of ther place)	Date :	2 Location - City or T	own, State
Ħ	permit. Pages Department of Importent: If I any injury or ance.		4 Donation 5 Other (Specif		22. Name	and Address of Facility	OTHE L	WILLIAM VACE	21229
Ba	Depa Impo any is		Mary 1 MA	nel	CARN	P. MARCH FI	WERA I Ale	no PAP	WITIME
	Dhysisian		23a. Part. Inter the disease, or com- shock, or heart failure. List only Immediate Gause (Final	rplications that caused the dear one cause on each line.	th. Do not enter the man	ode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical		disease(or condition resulting in death)	a. Due to (or as a conse	quence of):	ory name	<u>'C</u>		Do
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Division of Vital Records,	The law	Completed by					24a. Was a autops perforr 1 □ Yes	ned? prior to co	opsy findings available ompletion of cause of
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:	7500	Other	ath Check only on		4.
ō,	g Phys or this oral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	□ ER/Outpatient 3□ I	28c. Injury at Work?		ow injury occurred	<i>'y</i>)
ion	Attending Physician: r death. ector: After this certifice by the funeral director, p	atlo	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	on	Injury M	1 ☐ Yes 2 ☐ No			
Divis	tal or Attandii s after death. b! Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined		home, farm, street, fact ify)	ory, office	28f. Location (St City or Town	reet and Number or Rui i, State)	al Route Number,
0	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical		hysician: To the best of my kr miner: On the basis of examin and manner stated.					
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	111		30. Name and address of pers a who	completed cause of death (Ite	om 23a) (Type, Print)	000341	7	ully !	aurp
_	M		MARIA GAVII	RIA MD 38	OI HOSP	tal Dr Gle	i Burni	e MD 2	1061
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 3 201	2. Registrar's Sign	A STATE OF THE PARTY OF THE PAR				

		500-	1 - For State Registrar		State of	Marylar				ealth a		lental Hy	giene Reg. No.	006	13924
	Physici	an	Decedent's Name (First, Min		/iraini	Annl	U4-44					Date of De Month	ath Day	Year	
	/Medi	cal	4a. Facility Name (If not institu				Hostett		Town	Location of	of Death		pril 29,	2006 County of De	8:10 a. M
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	Funeral		5. Social Security Number	6. Sex			last birthday)		1 Year	If Under Hours		WSON 8. Date of Bir (Month, Da	th V Yearl	9. B	Baltimore inthplace (State or Foreign Country)
	Director		223.74.4315	1 📙	M 200 F		46 Yrs.	Months	Days	nours	MIII.			1	
	and		Usual Residence of Decedent 10a. State 10b. Cour	ıty		10c. Ci	ty, Town or Lo	cation				January :	26, 196	,0	Virginia 10d. Inside City Limits
	Mary -1 she lied	to	Maryland	Hov	<i>y</i> ard				_						1 □ Yes 2 No
	n 188	Director	10e. Street and Number					10f. Zip		olumbi	а		10g. Citiz	en of What C	Country?
	23a c		8845 Youngsea F	Place						210	045			U	.S.A.
Maryland 21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ≥ N 3 ☐ Widowed 4 ☐ Divorce	arried	2. Was Deced Armed Ford 1 Tes : If Yes, Give Year or Da	es? No	i	Was Dece If Yes, spe 1 Yes	1	spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)			nencan Indian,
20	72 hours natural',	ted	15. Deced (Specify only hig	ent's Educ			16a. Dece	dent's Usu	ai Occupa	ation	t of works		16b. Kin	d of Busines	
21	within 7, jiene. r then "n	Completed	Elementary/Secondary (0-12	- 1	College (1-	4or 5+)	life.	DO NOT u	se retired	uring mos)	t of works	rig		Boo	ok store
121	filed w Hygier sther th		17. Father's Name (First, Midd	la (aat)	5+				Ma	anager		<i>(C </i>			
anc	e la p	Be c			stetter, S	-				18. Mothe	ars Name	(First, Middle,			
ary.	d 2 should th and Men 7 Is marke traumatic	J.	19a. Informant's Name/Relation				19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	LISIE M		ite Thom.	
	12 h a 7		Ms. Ellen Thom	pson	Si	ster						ry, Tennes	-		-,,
ore,	of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crematic	. a 🗆 B		20b. F	Place of Dispo	sition (Na)	me of		D	ate			r Town, State
ij	Pages ment of I ant: If its jury or o	1	4 □Demation 5 □ Other	(Specify)	9		County Cr	ematica	n Serv	ices In	05/0	1/2006	,	Sykesvill	e, Maryland
Baltimore,	permit. Page Department Important: If any Injury o		21. Signature of Funeral Servi	e Licerse	/		22	. Name ar	nd Addres	s of Facilit	У				NA 8=1761 (070705997)
	ad E s d		23a. Part 1. Enter the disease,	or complie	o IV	1005 3	Do not ont	30	1866 FU 1871 OI	ıneral l d Colur	∃ome, nbia P	P.A. ike Ellicott	City. N	/ID 2104:	3 Approximate
	Physician /Medical		shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	ist only one	LUN	on line.	ANO	CE (2	, 30011 43	cardiac o				Interval Between Onset and Death Mouffes
	Examiner				Due to (o	r as a conseq	(uence of):								
*		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) b.	Due to (o	r as a conseq	juence of):								
	death certificate be executed e attending physicien and d for use as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last) c.											
8760,	be exected a		resulting in death) cast		Due to (o	ras a conseq	juence of):								
387	icate be ex physicien s the buria	dice		d.											
Box 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, outc	ome of pregna	ancy						22	3d. Date of de	playen
	the atter	Physician/Medical	in the past 12 months?		4 Pregna	th 2 ☐ Feta nt at time of d		Ectopic pi Other <i>(sp</i>					-	Month	Day Year
P.O.	≒ > ⊇	hys	9 Unknown		9L Unknov										
Division of Vital Records,	law requires that as been signed b 2 should be deta	Completed by		NET	AST A	tses	<u> </u>	nderlying c	ause give	n in Part I.				e contribute i	to the cause of death? Probably 4 Unknown
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alF	Th ate pag											1 Yes	rmed? No	death?	
Ž	Physician: T this certificat rat director, pa	o Be	25. Was case referred to medi examiner? 1 Yes 2 No		spital:		50/0		Othe	r		Check only o	1000		11
ō	g Phys er this erat dia	n: To	27. Manner of Death		28a. Date of		ER/Outpatien 28b, Time of		Bc. Injury Work	4 🗀 Nu		ne 5 🗆 Resid 28d. Describe h			ecity) FTEPICE
ioi	Attending F r death. ector: After by the funer	atio	1 Natural 5 Pen 2 Accident inve	ding stigation	(Month	Day Year)	Injury	М		? 'es 2 🗆 l	No				
<u>×</u>	f or Attendate after death Director:	Certification:	3 Suicide 6 Cou	d not be rmined	28e. Place o	f Injury - At he	ome, farm, stre	et, factory	, office		2	28f. Location (5 City or Tox	Street and	Number or F	Rural Route Number,
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	To the Hospital or Attending Physician: Within 24 hours after death. Within 24 hours Director: After this certific completely filled in by the funeral director.	ledical	one)	ai Exemin	cien: To the ber: On the bas and manne	is of examina	wledge, death ition and/or inv	restigation	, in my op	inion, deat	d place, a th occurre	and due to the ded at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)
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	10		30. Name and address of person		ipleted cause		п 23а) (Туре,	Print)		USON			120 Y		
	Sta	te	31. Date filed (Month, Day, Yea	r)	32/Ae	gistrar's Signa	iture /	wells	100	10 CV	, //	10. 2	120 4		
	Registr		MAY 0	3 200	b	Essen A	S. Salah								

8 10 A

Hostetter, Virginia 4/29/06

		For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of L			ene 2006	13925
Phys	ician dical	Joan	Lee Lee	Holli	day		2 Date of Death Month April 28	Day Y	3. Time of Death 5:30 P M
Exan Funer	niner al	4a. Facility Name (If not institution, 8468 Kavanagh I 5. Social Security Number	Road 6. Sex 7. Age	(In yrs. last birthday)	4b. City, Town, or Dund If Under 1 Year Months Days	Location of Death alk If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9	imore D. Birthplace (State or Foreign Country)
Direct	- 0	212-28-9829 Usual Residence of Decedent 10a. State 10b. County	1UM 2MF 74	10c. City, Town or Lo	ocation		Nov. 7,1	.931	Maryland 10d. Inside City Limits
ith the Ma or 28e-f	Director	Maryland 1 10e. Street and Number	Baltimore		10f. Zip Code	Dunda		g. Citizen of Wha	1 □ Yes 2 🖾 No at Country?
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland t Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28e-f ehow other traumatic event, the Madical Examinar must be notified at	by Funeral	8468 Kavanagh 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	9	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	spanic Origin? (Spanic Mexican, Puerto		14. Race -	American Indian, White, etc. White
21215-0036 sod within 72 hours af giene. er than "natural", or than Wedies! Exe in	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 9 Years	s Education	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of worki	ing	6b. Kind of Busin	ness/Industry
Maryland 2 d 2 should be filed th and Mental Hyg 7 Is marked other traumatic event, 1	o Be C	John George T				18. Mother's Name Edna	(First, Middle, Mae Stebl	aiden Sumame)	
'e, Maryla 1 and 2 should I Health and Meni tem 27 Is marke		19a. Informant's Name/Relationsh Mr. Michael Sh			ng Address (Street a		Clemente		ate, Zip Code) 92673
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			esition (Name of matory or other place t. of Jes	9)			ty or Town, State k, Maryland
Balt permit. Departi Import	SDCs	21. Signature of Funeral Service L	ne	D: 79	2. Name and Addres uda-Ruck 922 Wise	Funeral H Ave. Dun	dalk, Ma	ryland	Inc. 21222
S8760, A hitcaste be executed hitcaste be executed by physician and as the burial-transit	al er		a. Due to (or as a b. Due to (or as a c.		er the mode of dying		or respiratory arres	st,	Approximate Interval Between Onset and Death
Hecords, P.O. Box (The law requires that the death certif tte has been signed by the attending age 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknowh	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
COLdS, Pwrequires that been signed be should be deta	۵	Part it. Other significant condition	ns contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?
	Completed						24a. Was an autopsy performs	od? dea No 1□	re autopsy findings available or to completion of cause of the 2 D No
f VIT ysicial ysicial is certi directo	To Be		Hospital:	t 2 ER/Outpatien	nt 3 DOA Othe		me 5 Residen		(Specify)
DIVISION Of VITAI To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Certification: 1		ation	Ye <i>ar)</i> 28b. Time of Year) Injury	Work		28d. Describe how		
DIVISIC DIVISITE OF Attentions after death or all Director: lied in by the			building, etc.				City or Town,	State)	or Rural Route Number,
DI To the Hospitel or within 24 hours after To the Funeral Dir	Medical	29a. Certifier 194 Certifying (Check only 2 Medical E	Physician: To the best of xaminer: On the basis of and manner state	examination and/or in	vestigation, in my op	a date and place pinion, death occurr	and due to the nau ed at the time, dat	e and place, and	of at stated. I due to the cause(s)
To To mco	Σ	29b. Signature and title of certifier			29c. License				Month, Day, Year)
17		30. Name and address of person w		ath (Item 23a) (Type,	Print)	e (c O	W	ay 1,	2006
		Robert C. Dart	Jr 756	le work	Point P	Let Bell	mimune.	WID	21219
* 55% (* 12 hr	State strar	###N/ A 9 9:	006	's Signature		-			

			For State Registrar		S	State o	f Maryla		artmen rtificat				Mental Hy	giene	006	13925
	Physici		1. Decedent's Name	e (First, Middle		ammy	Ellen	Hylton					2. Date of De Month	aath Day	2006	3. Time of Death 10:53 A ^M
•	/Medio Examir		4a. Facility Name (/	f not institution r Balti	give stre	et and nui	nber)		4b. City,	Town, or	r Location o	of Death	APLL	4c. C	ounty of Dea	th
	Funeral Director		5. Social Security N 214-13-5	5170	6. Sex 1 ☐ M	2 ⊠ F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrş. Min.	8. Date of Bir (Month, Di Sept.	av. Year)	9. Bir 71 Ma	thplace (State or Foreign ountry) ryland
	Maryland f show	tor	Usual Residence of 10a. State Maryland	10b. County	altin	nore	10c. C	city, Town or Lo	ocation		Dur	ndall	k			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 3a or 28a	Funeral Director	10e. Street and Nur 1718 Kir		Road				10f. Zip	Code	212	222			ed Sta	
036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show saffael Examinar must be notilised at	à	11. Marital Status 1 Never Marri 3 Widowed			Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	27 No	U.S. 13.	Was Decedif Yes, special				ecify Yes or No Rican, etc.)		Black, Whi	erican Indian, te, etc. White
HALTON TANNY Baltimore, Maryland 21215-0036	72 nat	Completed	Elementary/Seco		t grade co	ion ompleted) College (1	-4or 5+)	(Give	dent's Usua kind of wo DO NOT us emake	rk done d se retired	ation during mos	it of work	ing		of Business	
land 2	be filed tal Hygi d other	To Be Co	12 Year 17 Father's Name Dale Ch	(First, Middle,		er, S	£.	Hom	emake	_			e (First, Middle Carol	, Maiden Si	umame)	
Mary,	and 2 should baith and Men n 27 ts marke ler traumatic		19a. Informant's Na Mr. Dal						ng Address 8 Kir				al Route Numb			Zip Code) 21222
HUTCH timore, M	Pages 1 thent of He tant: If Itan		20a. Method of Disp 1 Burial 2 4 Donation	☐ Cremation 5 🙀 Other (S _i	pecify) F	ioval from			Hill	Mem.	Gdns	s. 5,	Date /1/2006		ation - City or ddle R	Town, State
■ Balf	permit. Departr Imports any inj		21. Since ure of Fu	0.		7	Cou	03	uda-F 22 W:	uck ise 1	Fune:	ral 1 Dun	Home of	Dund Maryla	alk, I nd 21	nc. L222 Approximate
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8760, _ ≭	be executed icien and purial-transit	dicai Examiner	fany, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) i	>	c.		or as a conse or as a conse or as a conse	A	8 8 u	e p de	rea	id	em'	Sol	, ,	
P.O. Box 68	ath certific attending p for use as	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?	23c.	1☐Live b	come of pregrinth 2 Fet ant at time of own	al death 3	Ectopic pr Other (sp					23	d. Date of de Month	livery Day Year
rds, P	requires that the de been signed by the s should be detached	þ	Part II. Other signif	ficant conditio	ns contrib	outing to de	eath but not re	sulting in the u	nderlying c	ause give	en in Part I		23e. Did t	P	1	o the cause of death?
al Reco		Completed						-					24a. Was auto perfo 1 Yes	an psy prmtd2 2/21No	24b. Were as prior to death? 1 🗌 Yes	utopsy findings available completion of cause of
of Vita	Physician: Th or this certificete oral director, pag	; To Be	27. Manner of Lat	^ Мр	Vanier 1		npatient 2 [of Injury h, Day Year)	ER/Outpatier		Othe Bc. Injury Work	er: 4 □ Nu	irsing Ho	h Check only one 5 Resi	dence 6 [cify)
Division of Vital Records,	To the Hospitel or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	1-Natural 2 Naccident 3 Nuicide 4 Homicide	5 Pending investig 6 Could redetermine	ation ot be	28e. Place		Injury home, farm, str	М	101	k? Yes 2 ☐	-	28f. Location (City or To	Street and I wn, State)	Number or R	ural Route Number,
	e Hospitet on 24 hours a le Funeral Dietely filled i	ledical Ce	29a. Certifier (Check only one)	1 ertifyin 2 Medical I	g Physici Examiner	: On the bi	best of my kn asis of examin ner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) ar date and p	nd manner as lace, and due	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and	title of certifier	A	.13	Edoc	1	-	1 . 7	number 73	2		29d. Date :	signed (Mont	h, Day, Year)
	5		30. Name and addr GEOR(31. Date filed (Mon	RE B.	AS E) 0 /	W U7 []	om 23a) (Type,	Print)	V C	cha.	e/es	1 84	· Ba	160	Rd. 1120
	Sta Registi		M. Date med (MO)	AY 0 3	2006	No.	agistial s Sign	nature	also							

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day April 26, 2006 0949 hrs **Medical Examiner** Holly Calvin Bernard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 229 N. Mount Street Apt-103 **Baltimore** If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 30 35 Country) 70 212-32**-**5363 XXM Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No or 28a-f show permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 229 North Mount 21223 U.S.A. Street #103 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, 11, Marital Status Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No Black Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Medical MD 21215-0036 Public Works Baltimore City 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be traumatic event, Merrill Holly | TRELIII 1021 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 Thelma Hall 19a. Informant's Name/Relationship (Type, Print) Stephen Bethea-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2XX Cremation 3 Removal from State Crematory In¢. 5/3/06 Baltimore, md Metro Donation 5 Other Specify: 21. Signatur — Fulleral Service Licenses 22. Name and Address of Facility March F/H West 21215 300 Wabash Ave Baltimore, 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED ned by the attending physician detached for use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death Month 2 past 12 months? Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 호 1 Yes 2 No 3 Probably 4 V Unknown Prostate Carcinoma Completed After this certificate has been a funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? Yes 2 V N Yes 2 No To the Hospital or Attending Physician; within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other: Hospital: 4 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 Yes ۵ No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Director: d in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. ledical 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. April 27, 2006 MO 30. Name and address of person who completed cause of death (Item 23a) 1 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year, 2. Registrar's Signature

State Registrar MAY 0

			1 = For State Registrar	State of Marylan		artment of <i>tificate of</i>			giene 0 0 6	13928
To the second	Physici /Medic		Decedent's Name (First, Middle, Last) OSCAR DOYLI	E JOHNS	ON	JR		2. Date of Dea Month APRIL	Day Year	3. Time of Death 12:48P M
	Examin		4a. Facility Name (If not institution, give st FREDERICK MEMORIA	reet and number) AL HOSPITAL		4b. City, Town, FREDER	or Location of Deat CK	h	4c. County of Dea	
	Funeral Director		29 1 30 0 199 22	7. Age (In yrs. 69	last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birth Sept. 2	26, 1936 Pe	thplace (State or Foreign buntry) ennsylvania
	/aryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	with the has a or 28a-i	Director	10e. Street and Number 3641 Poffenberge	r Road		10f. Zip Code 2175	5		10g. Citizen of What Co	ountry?
950	permit. Pages 1 and 2 should be filed within 72 hours after death with fine Maryland Inopartment of Health and Mental Hygiene. Inopartment of Health and Mental Hygiene. In Indicate it is marked other than "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Maclical Examitment was trained at ODGs.	by Funeral		2. Was Decedent Ever in U. Armed Forces? 1 Yes XX No If Yes, Give Year or Dates:	1:	Was Decedent of f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		te, etc.
בו זי הרוזי	thin /2 hou e. an "natura Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life, L	DO NOT use retir	ed) aduring most of wo	rking	16b. Kind of Business	
7 .	Hygien Hygien Ither th	e Con	17. Father's Name (First, Middle, Last)	3	Comp	uter Pro	-	me (First, Middle,	County Go	vernment
	Mental Mental arked o	To Be	Oscar Doyle John	son, Sr.			Mari	an Barcl	ay	
Mar	d 2 sho th and the traums		19a. Informant's Name/Relationship (Type Mrs. Lynnda W. Joh			-			r, City or Town, State, . erson, Mary	
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	rtment rtant: H		4 Donation 5 Other (Specify)	PO			y April 29,			, Maryland
מ	Depa impo		21. Signature of Funeral Service Licenses	MO02	55 2	Këëhëy^ª 106 East	hd"Basfor Church S	d PA Fun St., Fred	eral Home lerick, MD	21701
, F	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line.	h. Do not ente	er the mode of dy		c or respiratory arr	rest,	Approximate Interval Between Onset and Death
E	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					70 70 70
4	D ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
,0070	icate be executed physician and s the burial-transit	dicai Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):		-			
00 X	ertification	0	IF FEMALE:	o Hugo outcome of progres						
.O. DO.	To the Hospital or Atlanding Physician: The law requires that the death certil within 24 hours after death, within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending Formpletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	I death 3	Ectopic pregnant Other (specify)	су		23d. Date of de Month	livery Day Year
cords, r	quires that in signed b uld be deta	ρχ	Part II. Other significant conditions cont EMPHYSEMA	ributing to death but not rest	ulting in the ur	nderlying cause g	iven in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
	alawre hasbee e 2 sho	Completed	HYPERTENSION					24a. Was a autop:	sy prior to	utopsy findings available completion of cause of
ונפו ע	ificate or, pag	e Cor	CITRONIC REVACI	DUSOFFICIE,	recy		26 Place of Do	performula 1 ☐ Yes ath (Check only or	2 No 1 ☐ Yes	2 No
5 5	nysicia his cert I direct	To B	examiner?	ospital: 1 Minpatient 2 🗆	ER/Outpatien	t 3 DOA			ence 6 ☐Other (Spe	ocify)
	ding P		27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju We M 1 [uryat ork?]Yes 2.∐No	28d. Describe hi	ow injury occurred	
	al or Atten s after deat Il Diractor: od in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre			28f. Location (S City or Town	treet and Number or Ri n, State)	ural Route Number,
	Hospin 24 hour Funers	edical (29a. Certifier 1 Certifying Physi (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
:	within 3	Med	29b. Signature and title of certifier	and marrier stated.			ise number	2	29d. Date signed (Mont	
_	1		Mary P. HE				46075		4/26/04	lo .
0	V		30. Name and address of person who con Mary P. Howell, M				rive, Fre	derick,	MD 21702	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2006	32. Registrar's Signa	ture					

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of L			giene Neg. No. 0 0 6	13929
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth	3. Time of Death
	 Physicia /Medic 		Catherine		G.	Jar	nes	Apri	Day Yeer	- 32 CM
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
	ŝ.		Sinai Hospital	of B	altimore	Box	Himore	-		
г	Funeral		5. Social Security Number 6. Sex 220–29–0171	7. Age	(In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year) C	rthplace (State or Foreign country)
	Director		Usual Residence of Decedent		12 113.			05 01	L 33	MD
	/land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Man, Ff sh	ţō	MD NA		Baltimo	re				1 Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What C	ountry?
	th wit		3833 Cottage A	ve			21215		U.S.A	
	dea	Funeral		Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi 1 Yes, specify Cubai	spanic Origin? (Sp	pecify Yes or No-	14. Race - Am Black, Wh	
9	or Ite		1 Never Married Married	1 ☐ Yes 2 🔀 N If Yes, Give	0	Tos, specify culcul	Specify:	riioari, etc.)	Specify:	
21215-0036	hours after death with the Maryland tural', or Items 23s or 28a-f show Items 23s or 28a-f show	d by	3 Widowed 4 Divorced	Year or Dates:		••				Black
5	"nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Deced	tent's Usual Occupa kind of work done d DO NOT use retired,	ition luring most of won	king	16b. Kind of Busines:	s/Industry
12	withi ene. than	mc	10th grade	College (1-4or 5-	+)	stodial			Chimes S	chool
	filed Hygi other ent.		17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Sumame)	
Maryland	ld be ental ked c	To Be	Horace Blackston	ne		3	Susie M	ae Turr	ner	
ary	shou ind M ind M ind M	_	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	g Address (Street a	nd Number or Ru	ral Route Numbe	r, City or Town, State,	Zip Code)
	alth alth alth a 27 li		Linda Mickle-Day	ughter	3833	Cottage	e Ave,	Baltimo	ore, Md	21215
ore	as 1 a		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location - City o	r Town, State
altimore,	Page ment ant: If ury o		1 X Burial 2 ☐ Cremation 3 ☐ Ro `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Garriso	n Forest	t Vet.	5/4/06	owings M	ills, Md
alt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event. It a Modical Examiner cust be notified at once.		21. Signature of Funeral Service License	•		Name and Address				
<u> </u>	20 E 2 9		Smette	K-ym	la 14	300 Waba	ash Ave		imore, Mo	21215
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not ent e.	er the mode of dying	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Pnysician	Ė	Immediate Cause (Final disease or condition	150	hemic	housel				Onset and Death
Ĺ	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	LAGITATIE		Sequentially list conditions, b		nival aa	tic an	eury	n re	pair	3 days
T	ed	Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury	Due to for as a	consequence of	4.	7			1
,	and al-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	ortic a	neurys	u.		year
8760,	cate be executed physician and the burial-transit	dlcal E					•			
89	ificate g phy as the	edic								
Box	that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		1 			23d. Date of de	livery
œ.	death e atte	icia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at t		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	at the by th tache	hys	9 🗆 Unknown	9□ Unknown						
ď.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by F	Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.		bacco use contribute t	. .
ord	equir sen si ould	ted	- rupertens	iou				1 U Y	es 2 No 3 P	robably 4 nknown
e C	law las be	Completed						24a. Was a autops	sy prior to	utopsy findings available completion of cause of
<u>=</u>	The	Cou						perfori 1 ☐ Yes	med? death? 2 No 1 ☐ Ye	s 2No
Vita	ician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?	ospital:		Otho		th (Check only on	ne)	
Division of Vital Records,	Phys this or	-T	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury		t 3 DOA Othe	4 Nursing Ho		ence 6 Other (Specow injury occurred	ecify)
UQ	ding F h. After funera	ig Ig	1 Natural 5 Pending	(Month, Day	Year) Injury	Work	ai ? ′es 2 □ No	200. Describe no	ow injury occurred	
18	l or Attendatter deatl Director:	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home, farm, stre			28f. Location (St	treet and Number or R	ural Route Number,
<u>S</u> .	after I Direct	Certification:	4 Homicide	building, etc.	. (Specify)	,,,		City or Town	n, State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Phys	icien: To the best o	f my knowledge, death	occurred at the time	e, date and place,	and due to the ca	ause(s) and manner a	s stated.
	he Ht n 24 he Fu	edical	(Check only 2 Medical Examin	er: On the basis of and manner stat	examination and/or inv	estigation, in my op	inion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	\cap \wedge \bullet		29c. License			9d. Date signed (Mon	/
			1 L Ken	Wolt	MD	Do	00634	92	4/27/0	06
	6		30. Name and address of person who cor	npleted cause of de	ath (Item 23a) (Type,	Print)	//	1 0 0	4/27/0 20/4/more	
				thouse 17	, MD	Sinai	Hospita	1 of B	a/findre	
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 3 2005	az. negistra	r's Signature	the s				

			1 - For State Registrer	State of Maryland		artment of H			iene	106	13930		
	ō		Decedent's Name (First, Middle, Last,		2. Date of Death								
	Physician LILLIAN B. JENKIN				5		Month	Day	Year	6.50PM			
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	04	18 4c. C	2006 ounty of Death	0.30		
1	LXIIII	iei	Catonsville	e commo	ns	Baltin	ore			,			
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs			9. Birth	place (State or Foreign		
	Director		212-36-9466 15	M 200F 100	Yrs.	Months Days	Hours Min	. (Month, Day, 08 10		Сош	MD		
	D D		Usual Residence of Decedent										
	rylar how	_	10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits		
	Pa-f a	cto	MD NA	Ba	ltimo	re					XXYes 2□No		
	다 다 9.72	- Le	10e. Street and Number			10f. Zip Code		1	0g. Citize	n of What Cour	ntry?		
	23a	a	4500 Frederick	Ave Apt C		2	1229			U.S.A.			
	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural" or items 23a or 28a-f show event, the Medical Eratinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Specify Yes or No-	es or No- etc.) 14. Race - American Indian, Black, White, etc.				
9	or it	J.F	1 Never Married 2 Married	1 □Yes XXNo If Yes, Give		1 ☐ Yes 21 No	Specity:		S				
ğ	ural',	Completed by	3 XWidowed 4 □ Divorced	Year or Dates:					ack				
21215-0036	nat nat		15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Deced (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of wo	orking	16b. Kind	of Business/In	dustry		
12	withir nne. than	d m	Elementary/Secondary (0-12)	College (1-4or 5+)					_				
	iled v tygie ther t		4th grade 17. Father's Name (First, Middle, Last)	na	Do	mestic		me (First, Middle, M		<u>rivate</u>	<u> </u>		
ä	ntal h	Be						de O'Nei		umame)			
Ë	d Me d Me mark matic	2	Duncan Maxwell 19a. Informant's Name/Relationship (7)	ma Print)	10h Mailie			ural Route Number,		Ct-1- 7:-	- Cd-)		
Maryland	d2sl han 7 Isr		Donna Tucker-Gr	eat anddaughter	370			arai Houte Number, S Ave, E			1.1		
	1 and Healt em 2 ther		20a. Method of Disposition							tion - City or To			
힏	it of it of or o		1 X Burial 2 ☐ Cremation 3 ☐ F	ionioval iloni State		sition (Name of natory or other place							
Baltimore,	rt Part	8	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funda Service Licens 					4/27/06	Lau	rel, M	id		
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Further Service Licens	- V. O.	, Ma	Name and Address	West						
	20244		C) Grette	1) Jenes				, Baltin		, Md	21215		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ne cause on each line.	. Do not ente	0.1		1			Approximate Interval Between Onset and Death		
			Immediate Cause (Final disease or condition resulting in death)	POSSI	Casella	anh	atrinia			hew hrs			
4			resulting in dealiny	Due to (or as a consequ	ence of):	1: 00	240	6					
			Sequentially list conditions,	b. ASTEND	OSSISTE CASELIAC Arrhythma a consequence of: tem DSCLUOTER CASELIO VESEULOU DIS						nany year		
J	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ance org:					0 0			
٣_	and and Il-trar	xan	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
8760,	icate be executed physician and s the burial-transit	alE											
387	phys the	dlcal		d	-								
×	ding se a	/Me	IF FEMALE:	23c. If yes, outcome of pregnar	ncv		00	23d Date of delivery					
Span								23d. Date of delivery Month Day Year					
o	the dr	ysk	1 ∐ Yes 2 🗷 No 9 🗍 Unknown	9□ Unknown	au	J. Other (specify)							
۵.	that ed by deta	/ Ph	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use	contribute to the	ne cause of death?		
ds	sign sign d be		Anomia Bu	east cancer	Sels	we diso	nder,	1 □ Ye	s 2 🗆	No 3 □ Prob	ably 4 Mnknown		
Ö	w require been si should I	ete	and in and t	east canoer	1 110	ne dian	2 - 0	04. 146		0.45	/		
န္တ	has has	Completed	Casalae arrygi	nivias, pepra	ully	er ausec	ne.	24a. Was ar autopsy perform	y	prior to condeath?	psy findings available mpletion of cause of		
a	r: Th		<u> </u>						No	1 🗆 Yes	2□ No		
<u> </u>	hysician: The law his certificate has t I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death (Check only								
o	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	To To	1 Yes 2 No	1 Inpatient 2 E	P/Outpatien	t 3L DOA	4 Nursing I	fome 5 ☐ Reside			y)		
L D		Certification:	1 Natural 5 ☐ Pending	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No				28d. Describe how injury occurred					
8		ical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be										
<u>></u>	or A after Direct in by	ertif	4 ☐ Homicide determined	building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	spital ours : eral filled	Š	29a. Certifier 1 Certifying Phys	sician: To the heet of my keep	ulada dost	Localizad at the firm	a date and ele-	and due to the	use(a) :	nd manner : : :	ntod.		
	24 hi Fun	edical	(Check only 2 Medical Exami	sicien: To the best of my know ner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my op	oinion, death occi	rred at the time, da	iuse(s) ar ite and pl	ace, and due to	the cause(s)		
	To the within 2 To the complet	2	29b. Signature and title of certifier			29c. License	number	29	d. Date s	signed (Month.	Day, Year)		
	F ≯ F ŏ		Doolma (Pa	UCA WID		1875	41		Am	d. Date signed (Month, Day, Year) From 1 20 2006			
	40		20 Name and other states	The state of the s	00=1 7	Dai-N	71		Pol	/ 44	,		
	3		30. Name and address of person who con GETH A R M	ompleted cause of death (Item	23a) (Type, 1 36フ 4	folling F	eru Ra	, Baltir	иощ	MD-	21227		
	Sta	to	31. Date filed (Month. Dav. Year)	32. Registrar's Signatu	ure a	الماليات	- U	/			,		
	Sta Registr		MAY 0 3 200	S ROL M	Ana	85 8							

			1 - For State of Maryla		artment of l		ind Me		jienje	06	13931
1	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Florence Mildred Jogere	it				2. Date of Dea Month May	th Day	2006	3. Time of Death 5:00am M
1	/Medio Examir		4a. Facility Name (If not institution, give street and number) Rose Manor Assisted Living		4b. City, Town, o	r Location of			4c. Co	unty of Death Howa	rd
	Funeral Director		5. Social Security Number 218−12−4646 6. Sex 1 M 2 T F 97 Usual Residence of Decedent	s. last birthday, Yrs.		If Under 2 Hours	Min.	B. Date of Birth (Month, Day Nov. 3	1908	9. Birthp Coun	lace (State or Foreign try) MD
e, Maryland 21215-0036	death with the Maryland ms 23a or 28a-f show rmust be notified at	ector		City, Town or L E11	licott Ci	ty					0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	s 23a or	Funeral Director	3100 N. Ridge Road	11.6		043	1-0/0		U	of What Coun	
	ours after de iral', or item Examiner	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ∰ Widowed 4 □ Divorced 12. Was Decedent Ever in Amed Forces? 1 □ Yes 2 ☑ No If Yes, Give A Year or Dates:		Was Decedent of HIF Yes, specify Cub	Specify:	in? (Spec Puerto R	ican, etc.)		Race - Americ Black, White, o ecify: Wh:	
	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "natural", or items 23a or 28a-f show other then "natural", or items 23a or 28a-f show event, the Madical Examinat must be notified at	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most d)	of working	g		of Business/Inc	
	should be filed and Mental Hyges that the other amarked other umatic event,		17. Father's Name (First, Middle, Last) Albert Barth			G	ertr	(First, Middle, lude McD	aniel		
	1 and 2 Health a bm 27 ls			Place of Dispo	ng Address (Street) Marriot osition (Name of matory or other pla Mem. Ga:	tsvill	e Rd	#2, Mar	riott 20c. Locati		MD 21104 wn, State
Balt	permit. Pages Department of I Important: If Ite eny injury or of		21. Signature of Funeral Service Licensee Suan A Haught	HA S	TGHTanf UN Sykesville	ERALaciin e, MD	OME 8	& CHAPE 4 (410)	L, PA -795-	(Box 1	195)
in of Vital Records, P.O. Box 68/60,	Certificate be executed the prize as the buffal-fransit and the purial-fransit and the puri	ilcai Examiner	23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of the conditi	equence of):	Dem			өзрнатогу ат	esi,		Approximate Interval Between Onset and Death
	atter for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	′			23d.	Date of deliver Month	y Day Year
	law requires that the d as been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.			pacco use o		e cause of death?
	The lar ate has page 2	Completed						24a. Was a autops perform 1 ☐ Yes 2	y	prior to con death?	sy findings available pletion of cause of
	ing Phy Atter this Ineral d	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28a. Place of Injury At building, etc. (Spec	home, farm, str	f 28c. Injur Wor M 1	er: 4□Nurs	sing Home 28	Check only on 5 Reside d. Describe ho if. Location (St City or Town	ow injury oc		Assiste Ping
	To the Hospital or Attandi within 24 hours atter death. To the Funeral Director: A completely filled in by the t	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my king the control of the basis of examiner: On the basis of examiner and manner stated.								ited. the cause(s)
		W	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Itt ATIT KUKUP 15 COES 17 COES 18	am 22al /T	29c. Licens Do	0 6 3	68	-1 2	9d. Date sig	gned (Month, D	ay, Year)
You is	∫ ()	te	30. Name and address of person who completed cause of death (Ite ATIT KURUP 115 Ces ATIT KURUP 115 Ces ATIT KURUP 115 Ces ATIT KURUP 132. Registrar's Sign	nature •	1,91	en Bu	(7N1	c 11.	D 01	060	
	Registr		MAY 0 3 2006	Agent							

			For State Registrar	State of Ma	ryland		artment of Hea <i>tificate of De</i>			ene 006	13932	
1	Physici /Medic		Decedent's Name (First, Middle, La	st) Alle	n W.	Kel:	Ly	2	Date of Death Month 4 2	Day Year	3. Time of Death 6:30 p. M	
	Examin		4a. Facility Name (If not institution, giv. 4 Wyndmoor P. 5. Social Security Number 6.5	lace	(In yrs. las	.,		vation of Death Under 24 Hrs. 8 ours Min. 8	Date of Birth	4c. County of Dea		
	Director		Usual Residence of Decedent 10a, State 10b, County		84 10c. City, 1		cation		6-18-1	921	Ga 10d. Inside City Limits	
	he Maryl 28a-1 eho ciille 1	ector	Md 10e. Street and Number		Balto		10f. Zip Code				1 X Yes 2 No	
Baltimore, Maryland 21215-0036	ath with Is 23a or 3	Funeral Director	4 Wyndmoor Pla				21207			g. Citizen of What C		
	72 hours after death with the Maryland natural", or Items 23a or 28a-f ehow Jicel Esaminat must be notified at	To Be Completed by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:			Was Decedent of Hispar f Yes, specify Cuban, M I ☐ Yes 2 🌠 No Si	nic Origin? (Speci lexican, Puerto Rii pecify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whi Specify: B1.	erican Indian, te, etc. ack	
	within ene. then "		15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 9th grade	Education grade completed) College (1-4or 5+) N/A 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer							b. Kind of Business/Industry Proctor & Gamble	
			17. Father's Name (First, Middle, Last Herbert Kelly)			18.	Mother's Name (A		-,		
	nd 2 shallth and 27 is m		19a. Informant's Name/Relationship (Shirley Chambers				g Address (Street and a					
	permit. Pages 1 an Department of Heal Important: if Item 5 eny Injury or other once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	y)	cem	etery, cren	sition (Name of natory or other place) Forest Vet	1	006	Oc. Location - City or Owings Mi		
Ва	permit Depar Impor eny In		21. Signature of Funeral Service Licer	· Thomp		JR		300 Waba	sh Aven	ue Balto,	Md 21215	
,	Physician ,/Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death // O M D T T T									
O. Box 68/60,	ficate be executed physician and sthe burial-transif	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):									
	death certii e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal de	ath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year	
ras, P	an and and and and and and and and and a	þ	Part II. Other significant conditions of	contributing to death but	4"		nderlying cause given in	Part I.			o the cause of death?	
Vital Records	The law ate has b page 2 s	Completed							24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of	
ō	Attending Physician: Thir death. ector: Atter this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1								icity)	
DIVISION	al or Atten after deal I Director: d in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)								ural Route Number,	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical C	29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge death incurred at the time data and place and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
)	To t withi To tl		29b. Signature and title of certifier	6 Our	Hus	m	29c. License nur	mber 7 / 5 7	290	d. Date signed (Mont	h, Day, Year)	
	1041		30. Name and address of person who RAYNOLD DEFO	completed cause of dea	ath (Item 23	Ba) (Type,	Print) BALTIMA	RE DO H	HO BA	LTIMARE	MD 21241	
1	Sta Registr	40	31. Date filed (Month, Day, Year) MAY 0 3	32. Registrar 2006	's Signatur	W. A	parlis	- / 15-17	1,4 1/11	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	m, Day, Year) 2006 MD 21244	

			1 - For State Registrar Amend #5 Pe	State of Maryl					giene	06	139	33
			1. Decedent's Name (First, Middle, Last)	er in Good	0/09/00	.0144.0		2. Date of De	ath		3. Time of	Death
	Physici /Medic		Cathryn Mary Kent					Month AFRI	Day	Year 2006	6:20	Ω М
*	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of D			ity of Death	less & proper phys.	
			Saint Joseph M	edical Ce	nter		Tow	son]	Balti	more	
	Funeral		5. 220 Se 1 8 2820 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	II Under 24 I Hours A	Hrs. 8. Date of Bir Vin. (Month, Da	th y, Year)	9. Births	place (State o	r Foreign
	Director		Usual Residence of Decedent	W 25X	81 Yrs.			Oct.23,		Balto	MD.	
	land ow		10a. State 10b. County	10c	. City, Town or Lo	ocation				1	10d. Inside Ci	ty Limits
	-f sh	tor	MD Baltimore	TD.	losedale						1 ☐ Yes	XXNo
	r 28a	Director	10e. Street and Number		Oseuale	10f. Zip Code			10g. Citizen o	f What Cour	ntry?	
	h with	al D	5401 King Avenue			21237			U.S.A.			
	dea	ner	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin	? (Specify Yes or No		ace - Americ		
36	or it	y Fu	1 Never Married 2 Marned	1 ∐ Yes 2 ሺ No If Yes, Give		1 ☐ Yes 2 🕅 No	Specify:	40.10 1 110411, 010.7	Spec		White	د
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or iteme 23a or 28a-f show with the Madical Examinat must be multified at	Completed by Funeral	3 ¼ Widowed 4 □ Divorced	Year or Dates:			-11					
7	n 72	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of	working	16b. Kind of	Business/In	dustry	
72	the the	шо	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)	House		,		Own 1	nome		
D	Hyg other	BeC	17. Father's Name (First, Middle, Last)		110 00 00		18. Mother's	Name (First, Middle,				
lar	Aenta Aenta tic ev	To B	George Butcher				Barba	ra Boehnl	ein			
Maryland	and h		19a. Informant's Name/Relationship (Typ	•		-		r Rural Route Number	•		Code)	
Σ.	and sealth n 27		Kathy Rosensteel/D					imore, MD	21206	5		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show any fujury or other traumatic event, the Madical Examinating must be indiffied at ODEs.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	b. Place of Dispo cemetery, crei	sition (Name of matory or other plac	θ)	Date	20c. Location	1 - City or To	own, State	
Ë	Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify)		_	of Faith		ıy 3, 2006				
3a	Permit Depar Tripor Iny In		21. Signature of Funeral Service License	е				Miller-Di				Inc.
_	do z e d		John ward					l, Baltimo		2120		
			2 a. Fart1. Enter the disease, or complice shock, of heart failure. List only on Immediate Cause (Final	e cause on each line.	Jeans Do not em	er the mode or dyin	g, such as care	diac or respiratory a	rest,		Approximate Interval Bet Onset and I	ween
	Physician /Medical			PNEUMONIA								
	Examiner			Due to (or as a con		CTC						Ÿ.
		ē	Sequentially list conditions. b.	Due to (or as a corr		ra				-		
	ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events									
oʻ	en an rial-tr	Exa	resulting in death) Last	Due to (or as a con	sequence of):							
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai	d									
9	ntifica ing pt	Med	IF FEMALE:									
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	the at	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)			10	ionth	Day 1	ear
O. O.	res thet the death certificing by the attending F be detached for use as	by Physician/Me	Part II. Other significant conditions conf	ributing to death but not	resulting in the u	nderlying cause give	on in Part I	23e Did to	obacco use co	ntribute to th	he cause of d	eath?
Division of Vital Records,	signe d be		Takin olio olganio olio olio olio	in butting to doctin but not	roodking in the d	ndenying cadae give	311 III F CAIC 1.		res 2⊡No	3 □ Prob		Inknown
Š	w require been si should b	etec			-			-				
Be	ne fav	Completed						24a. Was autor perfo	an 24b sy rmed?	prior to col death?	psy findings a mpletion of ca	ause of
a	n: Te	င္ပ	25. Was case referred to medical					1 ☐ Yes	2 No	1 🗆 Yes	2 X No	
5	Attending Physician: In death. Sector: After this certifica by the funeral director.	To Be	examiner?	ospital:	2 ER/Outpatier	nt 3 DOA Othe		Death (Check only only only only only only only only		thes (Coss)		
ō	9 Phy er this		27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe			у)	
ō	ath. r: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury		res 2 □ No					
<u>> </u>	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, larm, str	eet, factory, office		28f. Location (S City or Tox	Street and Num	nber or Rura	I Route Num	ber,
Ω	ital o	Çe	_		,,				,			
	Hosp 4 hou Fune ely fil	cal	(Check only 2 Medical Examin	ician: To the best of my er: On the basis of exam	knowledge, death	n occurred at the tim	e, date and pl	ace, and due to the	cause(s) and m	nanner as st	tated.	
	To the Hospital or Attending Physician: The I withing the Journal and death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29b. Signature and title of certifie	and manner stated.		29c. License						
	F S F O		29b. Signature and title of certifier	median	m.O				29d. Date sign	9 01	h on i	
	1		0. 0			D 41	41/2		111/16	20	100	v 0
	0		30. Name and ad ress of person who cor	npieted cause of death (лет 23a) (Туре,	Print)	ate the left of the					
	Sta	te	31. Date liled (Month, Day, Year)	32. Registrar's Si	ignature	ele D	- Cuwa	र्गमाण स्पाट	<u></u>	LEVIA		- 1
	Registr		MAY 0 3 2006	All mass of a	is proper	C STORES						

			1 - For State Registrar			ficate of De	alth and Ment eath	Reg. N	4000	10934
b	Physici	an	Decedent's Name (First, Middle, La.					ate of Death	ay Year	3. Time of Death
	/Medic Examin		ALFRED 4a: Facility Name (If not institution, give		AWSON,	LII. b. Cit y, Tow n, or Lo	cation of Death	7 - 2	c. County of Death	0630 M
	Funeral Director	er	Coastal Hos 5. Social Security Number 6. S 212-40-8585	pice at the	last birthday)	Sal f f Under 1 Year If	Under 24 Hrs. 8b.	ate of Birth fonth, Day, Year y 9, 194	Wico) 9. Birthp Court	
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Locat	ion			1	0d. Inside City Limits
	Manyli f eho	0			y	Crisfie	1.3		'	YSYes 2 □ No
	r 28a	Director	Maryland Some	LSec		10f. Zip Code	510	10g. C	itizen of What Cour	itry?
	ath with	rai D	223 North Somerse				L817		USA	
920	be filed within 72 hours after death with the Maryland all thygiene. A let the "activity or items 23a or 28a-f ehow other then "natural", or items 23a or 28a-f ehow event, the Madical Examinar mant be notified at	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Amed Forces? 1 □ Yes 2∑No If Yes, Give Year or Dates:		****	nic Origin? (Specify Y Mexican, Puerto Rican Specify:	es or No- , etc.)	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	within 72 ho ane. Ihen "natul	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give kin life. DO	t's Usual Occupation d of work done durin NOT use retired)	n ng most of working		Kind of Business/Ind	•
2	Hygie Hygie other		17. Father's Name (First, Middle, Last)	2	OV	ner 18.	. Mother's Name (Firs			LOLE
<u>a</u>	2 should be filed and Mental Hygis is marked other aumatic event, II	To Be	Alfred James Laws	on, Jr.		Rı	uth Bridde	11	,	
ary	s 1 and 2 should f Health and Menitem 27 is marked other traumatic	3	19a. Informant's Name/Relationship (19b. Mailing A	Address (Street and	Number or Rural Rou	te Number, City	or Town, State, Zip	Code)
	127 E D		Ann Ward Lawson (Carl Carlotte		set Ave	Crisfie	eld, MD 2	1817
Baltimore,	00		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐	Removal from State		ory or other place)	Date		_ocation - City or To	
			4 □ Donation 5 □ Other (Specify 21. Signature of Funeral/Service Licer		22 N	ame and Address of	April 30,		isfield,	Maryland
Ö	permit. Departimport. any inj.		May Both	Noblan Yus Ashaw-Printt	Bra	adshaw & S	Sons Funer Street -		ld. Marvla	and 21817
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death					IG/ TALLY I	Approximate Interval Between
, 1	Physician		Immediate Cause (Final disease or condition resulting in death)	· Metastatil	Colo	n Ca	ncer			Onset and Death
	/Medical Examiner		resulting in deality	Due to (or as a consequence	uence of):					
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	ecuted and transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						······································
60,	ificate be executed g physicien and as the burial-transit		resulting in deathly cast	Due to (or as a consequ	uence of):					
09/89	= D #	edicai		, d						
O. Box	at the death certif by the attending itached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	Ideath 3 □Ec	topic pregnancy her (specify)			23d. Date of delive Month	ry Day Year
rds, P	ires that signed by d be deta	by Ph	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the unde	rlying cause given in	Dari 2	3e. Did tobacco	use contribute to th	e cause of death?
0	3 € 5	9					raiti.		o 3 □ Prob	ably 4 Unknown
	The law requires that the rate has been signed by the page 2 should be detached.	Completed					2		24b. Were autop prior to con death?	ably 4 Unknown osy findings available inpletion of cause of
		Be Completed	25. Was case referred to medicat examiner?	Hospital		26	2	1 Yes 2 4a. Was an autopsy performed? Yes 2	24b. Were autop prior to con death?	osy findings available
or Vital	Physician: this certifice ral director, p	To Be		28a. Date of Injury		26 3 DOA Other:	2 . Place of Death (Che	1 Yes 2 4a. Was an autopsy performed? Uses 1 No. No. No. No. No. No. No. No. No. No.	24b. Were autor prior to cor death? 1 Yes 6 Other (Specify	osy findings available inpletion of cause of
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JIVISION Of VITA	Attending Physician: ar death, sector: After this certifice by the funeral director,	Be	examiner? Yes	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hobuilding, etc. (Specify	28b. Time of Injury ome, farm, street, /)	26 Other: 28c. Injury at Work? M 1 Yes factory, office	2 1. Place of Death (Che I Nursing Home 5 28d. D 2 No 28f. Lc	1 Yes 2 4a. Was an autopsy performed? Yes Note only one) 5 Residence describe how injuited on the order of	24b. Were autop prior to cor death? 1 Yes 6 Other (Specify any occurred	osy findings available inpletion of cause of service of
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06-02884 Nancy I. Linton ARLEASe Type or Printin Black Indelibled not a State of Maryland / Department of Health and Mental Hygiene

		Registrar	Certificate of	f Death		Reg	g. No. 4	00 10300
Physici Medical Exam			ee Linton			Date of Death Month April 29, 20	Day Year	3. Time of Death 1026 hrs
		Facility Name (if not institution, give street and number) St. Agnes Hospital		4b. City, Town, or L Baltimore	ocation of Death		4c. County of N/	
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24Hrs. 8	B. Date of Birth		
Director		213 36 3502 _{1 M 2} X F 66		Months Days				9 Birthplace (State or Foreign Country)Maryland
		Usual Residence of Decedent			<u>f</u>	OV. 29	, 2006	Janu y Land
any			. City, Town or Locat					10d. Inside City Limits
Maryland 28a-f show d at once,	'n	Maryland Baltimore	Baltimo	ore				1 Yes 2 X No
Maryl. 28a-f dato	Director	10e Street and Number		10f. Zip Code		10	g. Citizen of Wha	at Country?
ith the Maryland 23a or 28a-f sho notified at once.		806 Regis Court		212	227		U.S	•
th wit ems 2 t be n	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces?			anic Origin? (Speci Mexican, Puerto Ric		14. Race - White,	American Indian, Black,
er death , or ite	F	3 Widowed 4 Divorced If Yes, Give Year	No		·	,,		
hours afte 'natural'', Examiner	ð	15. Decedent's Education (Specify only highest grade complete		4.6	specify: on (Give kind of work	done	Specify: 16b. Kind of Bus	White
72 hou "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	during m	ost of working life. I	DO NOT use retired)		TOD, Tand or Dad	in load in laddiny
21215-0036 uld be filed within 72 Mental Hygiene marked other than '	ompleted	9th		Homemaker	r		Own	Home
5-0 iled w Hygie I othe	ပ	17. Father's Name (First, Middle, Last)	•	18	8.Mother's Name (Fi		,	-
121 d be fi lental arked svent,	Be	Charles B. Kelley				G. Pal		
_ 2 p s :	L _o	19a. Informant's Name/Relationship (Type, Print) Susan Micucci / Daughter			and Number or Rura			ie, MD 21061
more, MD ages I and 2 sh ent of Health an nt: If item 27 i		20a. Method of Disposition	20b. Place of Dispos	sition (Name of ceme				City or Town, State
Baltimore, bermit Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State	Bayview C		5/4/2	2006	Baltimo	re, Maryland
aftin nit Partmen artmen sortan iry or		4 Donation 5 Other Specify: 21 Superature of Fin at Service Licensee						vice, P.A.
Balt permit Depart Import injury		MATC	400)1 Ritchie	e Highway	Balti	imore, M	aryland 21225
Physician		3a. Part . Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter t	he mode of dying, s	uch as cardiac or re-	spiratory arres	st, shock, or hear	t Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Atherosclerot	tic cardiova	sular disea	se			Death
		or condition resulting in death) Due to (or as a conseque	nce of):					
	e	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque	nce of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
cuted ind transit		events resulting in death) Last Due to (or as a conseque d.	nce of):					
an an all -	an/Medical	Xunpended X amended item#	1,23a,PI,27,	perME,g855,	5/10/06 TT		· <u> </u>	
68760, ertificate be ex ding physician	Mec	IF FEMALE: 23c. If yes, outcome of		- ,,			23d. Date of d	elivery
687 ertific	ian/	23b Was decedent pregnant in the past 12 months?		tal death 3	Ectopic pregnancy		Month	Day Year
O. Box 6 at the death cer I by the attendi	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	ordeath 5 Ot	her (Specify)				
D. E		Part II. Other significant conditions contributing to death but	not resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
P.O ires that t signed by	d by	Chronic obstructive pulmonary dis	sease			1 Yes	2 No 3	Probably 4 🗸 Unknown
ords, v requir s been s should	Completed				· -	24a Was ar		ere autopsy findings available
eco ne law te has ge 2 sl	μŽ					autopsy perform 1 ✓ Yes 2	ned? de	or to completion of cause of ath?
tal Rectian: The certificate ector, page		25. Was case referred to medical		26.Place o	of Death (Check only		INO	Yes 2 No
Vita hysicia this ce	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient	2 V ER/Outpatient	3 DOA	other Nursing H	ome 5 R	esidence 6	Other:
n of ing Pl After unera		27. Manner of Death 1 X Natural 5 Panding (Month, Day, Year)	28b. Time of I	njury 28c. Injury	at Work? 28d	d. Describe ho	w injury occurred	
ivision or Attend after death. Director: I in by the f	atio	Natural 5 Pending Accident Investigation		1 Ye	es 2 No			
Division of Vital Records, rate or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	Suicide Could not be	- At home, farm, stree	et, factory, office bui	ilding, etc. 28f	Location (Strong Town, Sta		or Rural Route Number, City
spi fil		4 Homicide determined (Specify) 29a Certifier						
To the Howithin 24 P. To the Full Completely	Medical	(Check only one) Certifying Physician: To the best of my known one) Medical Examiner: On the basis of examination						
To To	Mec	and manner stated. 29b Signature and title of certifier		29c. License				(Month, Day, Year)
		ton (1. Klo.		O.C.M	I.E.		April 30, 200	
Kad		30. Name and address of person who completed cause of death	(Item 23a)		4.			
D * Frend		Patricia Aronica-Pollak MD. Assistant Medi	,	111 Penn Stre	eet, Baltimore, I	MD 21201		
	ate	31. Date filed (Month, Day Year) 2006 32. Registrar's Si	gnature	120				

			1- State of Maryla					_	6	13936
	ka Ka a	<i>y</i>	Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death
	Physici /Medic		Mary Yolanda Lombardi				May		₀ 06	3:40 AM
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death	3	4c. County of		-
***			St. Agnes Hospital		Baltim	iore				
	Funeral	o-text	454.085	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthp	lace (State or Foreign try)
9	Director		212-10-7004 91	Yrs.			Oct.26	, 1914	New]	York
3 No	and		Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Lo	ocation				10	Od. Inside City Limits
Yolanda	the Maryland 28a-f show	ō	Maryland Baltimore C	a + a n a	11.					1 ☐ Yes 2 ☑ No
フ	the 28a	rect	10e. Street and Number	atonsvi	10f. Zip Code			10g. Citizen of W	hat Coun	try?
7	ous after death with the Marylar rel', or thems 23a or 28a-f show Examinar most be notified as		1515 Copeland Road		2122	20		USA		
Mary	ms 2	era	11 Marital Status 12. Was Decedent Ever in	U.S. 13.		ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No			an Indian,
Σ_{0}	or the	Fu	1 Never Married 2 Married 1 Fyes, Give		If Yes, specify Cuba 1 □ Yes 2 ② No		Hican, etc.)		, White, i Whi	
4i.	hours after tural', or its	d b	3 XWidowed 4 ☐ Divorced Year or Dates:		TES ZEFNO	<i>Зреспу:</i>		Specify:	*****	
ombardi, d 21215-0036	72 hours natural	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa	ation during most of worki d)	ng	16b. Kind of Bus	iness/Inc	lustry
-2 <u>1</u> 2	within ene. then	шр	Elementary/Secondary (0-12) College (1-4or 5+)			1)				
22.2	t Hygiene. t Hygiene. other then	ပိ	10 17. Father's Name (First, Middle, Last)	Home	maker	18. Mother's Name	(First Middle	Own Maiden Surname		
and and	ntal hed ol	Be	Lee Liberto Monaco			Josephine			,	
2	2 should be and Mental Is marked o	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b Mailii	ng Address (Street :	and Number or Rura			State Zin	Code)
≅	nd 2 salth an 27 ls 27 ls r trau		H H W	577,73712	3cs 3a					,
စ်	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. Item 27 is marked other then "natural other traumatic event, it a Medical		Anita Riley Daughter 20a. Method of Disposition 20b.	Place of Dispo	osition (Name of matory or other place		ate	20c. Location - 0	City or To	wn, State
ê E	m O - L		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) La		Mem. Par		2006	Sykesvil	le. N	Marvland
Lombardi, 1 Baltimore, Maryland 21215-0036			21. Signature of Funeral Service Licensee	1 2	2. Name and Addres	ss of FacilitySter	ling A	shton Sc		
Ö	Depa Impo any I		(Mha Kall		Funeral E	Home of Ca ondson Ave	itonsvi. enue: C.	lle,Inc. atonsvil	1e. N	n 21228
			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardiac c	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	aana lia	hemorr	1	roke			Onset and Death
Mar.	/Medical		resulting in death) Due to (or as a conse		Hember	iagic 31	10,02			·
·	Examiner		Sequentially list conditions, b. Atrial	fibril	lation					
1/2	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	equence or):	200 T (Fac.)	0000				
6	s be executed sician and burial-transit	xar	that initiated events resulting in death) Last c. Due to (or as a cons-		ery_clise	are			-	
760,	icate be e. physician s the buria	calE	d. Huperl	ensim	-					
.89	leath certificate L attending physic			7H-752.						
Вох	h cert andin use	N/	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fe		Ectopic pregnancy			23d. Date	ol delive	ry
œ.	deat	100	1 Yes 2 No		Other (specify)			Mon	th	Day Year
P.O.	at the de I by the a stached	Physician/Med	9 Unknown							
<u>ග</u>	The law requires that the death certifical tie has been signed by the attending phyage 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.		_		e cause of death?
ord	w require been si should I	sted					10	Yes 2 No		ably 4 Unknown
Division of Vital Records,	e 2 si	Completed					24a. Was autop		ere autor lor to con	psy lindings available inpletion of cause of
<u> </u>							1 Yes		Yes	2 No
Z Z	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Acceptance of the control o		other actions of the	26. Place of Death				
of	Phy this	: To	1 Yes 2 No 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	☐ ER/Outpatier 28b. Time o	" 30 DOX]	4 Indising no		dence 6 Othe)
on	Attending I r death. ector: After by the funer	tlor	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Worl	k? Yes 2 □No		, , , , , , , , , , , , , , , , , , , ,	_	
<u>Visi</u>	Attendi r death. ector: A by the fu	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, str	reet, lactory, office		281. Location (Street and Numbe	r or Rura	Route Number,
ā	safte safte at Dir	Certification;	4 Homicide determined building, etc. (Spec	ony)			City or To	vn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my king the physician of the basis of examination and manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) and man date and place, a	ner as stand due to	ated. the cause(s)
	To t Withi To tl	Σ	29b. Signature and title of certifier		29c. License			29d. Date signed		
	t		13 ichlung 111 Tinn		1/54	1996		May 1	, 200	06
	6		30. Name and address of person who completed cause of death (Its Bichhuong M. Dinh 900 S	em 23a) (Type, Cata	Print) Ave nue	2, Box 6	10. Ra	(timoro	M	9 21999
7	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Sig		. 777 0710	1-7	-1 54	.,,,,,,,,	1	, www.pv.pv 1
	Registr	ar	MAY 0 3 2006	1 100	affect to					

			1 - For State Registrar	State of Maryla	and / Depa <i>Ce</i>	artment of rtificate o	Health and f Death	Mental Hy	/giene	13937				
	District Co.		1. Decedent's Name (First, Middle, Last)			-		2. Date of D	eath	3. Time of Death				
1	Physici /Medi		William Lavaughn	Mitchell				AF	RIL ^{Day} 29, Ž	7006 5:15 AM				
7	Examir	er	4a. Facility Name (If not institution, give s Saint Joseph	treet and number) Medical Co	enter	4b. City, Town	or Location of Dea	ath JSON	4c. County of	Death altimore				
	Funeral Director		420-70-9343	M 2□ F	rs. last birthday) 65 Yrs.	If Under 1 Year Months Day		n. (Month, D	lav. Year)	Birthplace (State or Foreign Country) ississippi				
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits				
	r 28a-f show	tor	Maryland Baltimore		odstock					1 ☐ Yes 2 No				
	r 28a	rec	10e. Street and Number	WC	JOUSTOCK	10f. Zip Code			10g. Citizen of Wha	at Country?				
	th with 23s or	a D	3604 Granite Road			21163			USA					
36	or items	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 31☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Decedent o If Yes, specify Cu 1 ☐ Yes 2 ☐ XN	Hispanic Origin? (ban, Mexican, Pue o <i>Specify:</i>	Specify Yes or Nerto Rican, etc.)		American Indian, White, etc.				
Ö	72 hours 'naturs!',	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occ	upation		16b. Kind of Busin					
215	- 23	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give		e during most of w	orking	100. 74.110 01 2001					
21	giene giene er the	ĕ	12	College (1-401 54)	Elect	rical E	ngineer		Defense	Contractor				
P	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						e, Maiden Sumame)					
yla	Ment Ment arke	၉	William Nathan Mit				Adele W							
, Maryland 21215-0036	and 2 sh raith and 27 is m er traum	The second	19a. Informant's Name/Relationship (Typ. Karin Mitchell Dod)						ber, City or Town, Sta S, MD 210					
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Illia M. ODGe.			emoval from State		natory or other p	/	ayate2,	20c. Location - Cit Beltsvill					
al‡i	mit. F partm portar / injui		21. Signature of Funeral Service License				٠,							
ä	F 0 E 2		Devel of the	Burial 2 Cremation 3 Hemoval from State Chesapeake Crematory 2006 Beltsville, Ma										
	Physician /Medical	i	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the de	eath. Do not ent	er the mode of d	ring, such as cardia	ac or respiratory	arrest,	Approximate Interval Between Onset and Death				
	Examiner		f.	240 10 (0) 43 4 00113	roquerice or,									
8760, K	cate be executed physician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons										
87	cate be e physician the buria	dical	d											
.O. Box 6	death certifi e attending id for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ic. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnar Other (specify)	су		23d. Date o Month	f delivery Day Year				
<u>α</u>	that the	F.	Part II. Other significant conditions con	ributing to death but not r	esulting in the u	nderlying cause o	iven in Part I.	23e. Did	tobacco use contribu	te to the cause of death?				
ords,	w requires that the been signed by th should be detache	ted by	UPPER GASTROINTES					10	Yes 2 XNo 3[☐ Probably 4 ☐Unknown				
of Vital Records,	The law ete has b page 2 st	Comple	DISSEMINATED INTR	AVASCULAR CO	DAGULATI	ON		24a. Was auto perf 1 ☐ Yes	s an 24b. Wer prior 2 No 1					
/ita	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	agaital to d				eath (Check only	one)					
of	Phys this at dii	၉	1 ☐ Yes 2 No ☐ 1 ☐ Yes 2 No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Yes 2 ☐ Y		☐ ER/Outpatien 28b. Time of	I 3LI DOA			idence 6 Other (Specify)				
L	ding After fune	0	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Inj W	uryat ork?]Yes 2∐No	28d. Describe	how injury occurred					
Division	ten feat for: the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	thome, farm, streetfy)			28f. Location (City or To	(Street and Number own, State)	or Rural Roule Number,				
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Phys	cian: To the best of my ker: On the basis of examinand manner stated.	nowledge, death	occurred at the restigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)				
_	To the within To the Complete	Me	29b. Signature and title of certifier	of a	1	29c. Lice	se number		29d. Date signed (A	onth, Dey, Year)				
	li n		1 Comercy	Jowill	le Ve		4034		5/1/	06				
	7,		30. Name and address of person who cor		em 23a) (Type, OSLER	,	TOWSON	I, MARYLI	AND 2120	4				
g	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Sig	nature	BI								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 6:15 AM 4a. Facility Name (If not institution, give street and humber) May 2006 /Medical 4c. County of Death Examiner Baltimore 5. Social Security Number ef Maryland Medical Conter If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 4 2 F -68-735 0 Yrs. Director March maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or Iteme 23a or 28a-f show vent, the Madical Examb en must be notified at 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Edgewoor Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2 No Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ma Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) aborer Department of Health and Mental Hygie Important: If Item 27 is marked other times in Injury or other traumatic event, Itagones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be 2 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number of Rural Route Number, 2813 Kelly - Cousin Gresham-way Woodlaw inda 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. 2100 4 Donation 5 Other (Specify) 21. Signature of Femeral Service Linense. 22. Name and Address of Facility 21229 ton 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying shock or bearthailure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease of condition resulting in death) **Physician** Acc erebrovascular /Medical Due to (or as a consequence of): Examiner Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oncei Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atter in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 7 24a. Was an Was a autopsy performed? page 2 s certificate 1 Tyes or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ZNatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) May 2006 P19836 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grene Street Baltimore Maryland 21201 Mes 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 29, 2006 Nancy Marie Moore **Physician** 4:15 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville Carroll 6515 Ken Mar Drive If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 214.30-58 72 Yrs Director March 5, 1934 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show 1 ☐ Yes 2X No Director Sykesville Carroll Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral', or Items 23a or Examine multiple U.S.A. 21784 6515 Ken Mar Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 W No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: Specify. 3 ☐ Widowed 4 ☑ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at home Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other that homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Marie McQuigan Richard Vernon Moore ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6515 Ken Mar Drive Sykesville, Maryland 21784 Ms. Anne Wheeler Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 05/03/2006 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park, Inc. 21. Signature of Funeral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastatic yea no resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 5 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 20 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Atter thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2006

arole

30. Name and address of person oco eted cause o death (Item 23a) (Type, Print)



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			1 - For State Registrar	State of M		Departmer Certificat	nt of H	lealth a	and M	lental Hyg	•) 6	13940
П	Dhusisi		1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		ALICE MALINDA	MAYHEW						May	1,	2006	9:30 p M
	Examir	er	4a. Facility Name (If not institution, give	street and number)				r Location of	of Death			nty of Death	
<i>j</i> a	*		702 4th Street 5. Social Security Number 6. Se	7 00	je (In yrs. last bii		urel	- If Under	24 Hrs	O Date of Bigh			orge's
	Funeral Director			DM 2只 F 7. AG		Yrs. Months		Hours	Min.	8. Date of Birth (Month, Day Apr. 29	, 1922	9. Birthp Cour	olace (State or Foreign otry) Utah
	e-f show	ctor	10a. State 10b. County Maryland Prince (George's	10c. City, Tow Hyat	m or Location						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28	Oire	10e. Street and Number			10f. Zi	Code			1	0g. Citizen o	of What Cour	ntry?
	ath w	rail	4715 68th Place				0784				U.S.A		
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itame 23a or 28e-1 show event. The Medical Exeminer must be notified a	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 2 If Yes, Give Year or Dates:)			ispanic Ori an, Mexicar Specify:		ecify Yes or No- Rican, etc.)		ace - Americ lack, White, offy: Wh:	
בֿ ה	72 ho	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a	. Decedent's Usu (Give kind of wo			t of worki	na	16b. Kind of	Business/Inc	dustry
N	within 72 ene. than 'na'	Completed	Elementary/Secondary (0-12)	College (1-4or		life. DO NOT L	se retired	1)	COT WORK	ng			
	e filed withi al Hygiene. I othar than vent, the M		Grade 12 17. Father's Name (First, Middle, Last)		P	ayroll (lerk		r's Name	(First, Middle,		unting	<u>a</u>
yland		To Be	Wilfred Oliver Sno	owden						leanore		,	
Mar	s 1 and 2 should if Health and Mer Item 27 le marke other traumatic		19a. Informant's Name/Relationship (7			Mailing Addres							Code)
	es 1 and 2 of Health a fitem 27 is r other tra		Patricia Mae Mitch 20a. Method of Disposition	nell / dau	_	702 4th f Disposition (Na		eet 1		el, Mary	Land 20c. Location	20707	State nwn
Baitimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot ance.		1 XBurial 2 ☐ Cremation 3 ☐		cemete	ry, crematory or	other plac						
	artme orten injury	. 1	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen.		MD ve	terans (_		_		ennam,	Maryland
n	Dep Imp		16856n		100770					Iome, P. Laurel		land	20707
			23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final	lications that cause one cause on each li	d the death. Do								Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		atory F							-	
	Examiner			ì	u consequence	01).							
	n =	ner	Sequentially list conditions, If any Jueting to immediat cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury)										
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
Ď,	ate be executed hysicien and the burial-transit	Ē	resulting in death) cast	Due to (or as	a consequence	of):							
68/6U,	physicate to the the the the the the the the the the	dicai		d									
C. BOX C	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XIX o 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s _i					1	Date of delive Month	ery Day Year
JS, T	requires that the een signed by th hould be detache	by	Part II. Other significant conditions of Lymphoma of Lung		out not resulting i	n the underlying	ause give	en in Part I.			bacco use co		ne cause of death?
Ö	v requ	etec	COPD										
Hecora	The far ate hes page 2	Completed	COFD						_	24a. Was a autops perform	Sy .	prior to cor death? 1 \(\sum \text{Yes}\)	psy findings available inpletion of cause of 2XXNo
VII a	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hassital.			1.00			(Check only on			Daughter
ō	Phys this al dii	. To	1 ☐ Yes 2√√No 27. Manner of Death			tpatient 3 De	28c. Injury	er: 4 □ Nu		ne 5 Reside			nesidence
	iding Phys th. : After this i	tion	1XXVatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	njury M	Work	k? Yes 2 □		zad. Describe in	ow injury occi	uried	
VISION	r Attender death	ertification:	3 ☐ Suicide 6 ☐ Could not be	286. Place of In	ury - At home, fa	arm, street, factor						nber or Rura	l Route Number,
5	s afte	Cert	4 Homicide determined	building, et	c. (Specify)					City or Towi	n, State)		
	To the Hoepitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best iner: On the basis o and manner st	t examination an	a, death occurred ad/or investigation	at the tim	ne, date an pinion, dea	d place, a	and due to the cand at the time, d	ause(s) and r ate and place	manner as st e, and due to	tated. the cause(s)
	To the within To the Compl	Me	29b. Signature and little of certifier	T. 1. 1	11116	29	c. License	a number		2	9d. Date sign	ned (Month, I	Day, Year)
			Suma	exam	1441)		D 5	4049			May 2	, 2006	6
	13		30. Now e and address of per who										
	The second		Reema Jalali, M.D.	7350 Va	an Dusen	Road	130	LAur	cel,	Marylan	d 207	07	
140	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2006	Z. Hegistr	ai s oignature	The same							
150		N. 146	MAY 03 ZUUD	S. Programme	-/								

Lawrence McCray, Jr.

Please Type or Print in Black Indelible Ink

State of Maryland /	Department of He	ealth and Menta	ıl Hygiene

1- For State Registrar Physician/ 1. Decedent's Name (First, Middle, Last)			•	Certificate of Death				Reg. No.	2006	1394	
Med	ledical Examiner Lawrence 4a. Facility Name (if not institution, give street and numbers)				McCra	y, Jr.		2. Date of De Month April 21,		Year	3. Time of Death 1615 hrs
	8		4a. Facility Name (if not institution, give str 3503 Bonfield Road	eet and number)		4b. City, Town, o	r Location of D		4c. C	ounty of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday		ar If Under 24	4Hrs. 8. Date of E	Birth(MM/DD	/YYYY) 9. Birti	nplace (State or
ı	Director		217-52-5099 1XM	2 F	54	Yrs. Months Day	ys Hours	Min. 6-28	<u>-1951</u>	Foreigr Cou	ntry) Md
	ans	-	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				— Т	10d Inside City Limits
	* o	_	Md. NA		Ba	ltimore					1 X Yes 2 No
	Maryland 28a-f show d at ouce.	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Coun	try?
	th the Maryland 23a or 28a-f sho notified at ouce		3503 Bonfield Rd.	2. Was Decedent Eve		212 Was Decedent of Hi	191	/ Cassif. Vac or	lo 14	USA	an Indian, Black,
	AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiers and Mental Hygiers or 17 is marked other than "natural", or items 23a or 28a-fish matic event, the Medical Examinor must be notified at once immatic event, the Medical Examinor must be notified at once	uneral	11. Marital Status 1 Never Married 2 Married	Armed Forces? Yes 2 X		If Yes, specify Cuba			10-	White, etc.	arrindan, blook,
	after d al", or	by F.	3 Widowed 4 Divorced If Y	es, Give Year Dates:	1	Yes 2X No				pecify: Bla	
	hours natur		15. Decedent's Education (Specify only harmonic Elementary/Secondary (0-12)	ighest grade complet College (1-4 or 5+)		dent's Usual Occupa g most of working life			16b. Kind	d of Business/Ir	ndustry
	5-0036 Iled within 72 Hygiene. I other than	Completed	12th grade	oomege (,	Add	iction Sp	ec.		Sta	te of M	d.
	15-0C		17. Father's Name (First, Middle, Last)	7.	Mccray	Cr.		lame (First, Middle ertha	, Maiden Su	rname) Hatch	ett
	ID 21215-00; should be filed with and Mental Hygiene 7 is marked other ti	To Be	Lawrence 19a Informant's Name/Relationship (Type	A.		illing Address (Stre			umber, City		
	MD d 2 sho lth and n 27 is numati		Patricia McCray	Wife		761 Clark					
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin		20a Method of Disposition 1 Burial 2 Cremation 3	Removal from State	crematory of	sposition (Name of corrother place) ount Cem.	- 1	Date 5-1-06		cation - City or altimor	
	도 스 한 글 날		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses		Greeing 12	e, Md.	21202				
	Balti permit Departm Imports injury o		Il lady i	O ane		March F.		110)1 E.	North A	
T	Physician /Medical		23a. Part I. Enter the disease, or complica failure. List only one cause on each	line.				iac or respiratory a	rrest, shock	k, or heart	Approximate Interval Between Onset and
V	Examiner			Atherosclero		vascular dis	sease				Death
he.		L	Sequentially list conditions, b.								
Ļ	*	Examine	(Disease or injury that initiated	e to (or as a conseque							
	rted J ansit	Exal	events resulting in death) Last	e to (or as a conseque	ence of):						
	760, icate be executed physician and the burial - transit	/Medical	X UNPENDED	MENDED item#	23a,27,per	ME,g855,5/2	4/06 TT				
		/Me	the state of the s	23c. If yes, outcome of		Fetal death 3	Ectopic pr	egnancy		Date of delivery	ay Year
	Box 68 e death certif the attending ed for use as	iciar	past 12 months?	4 Pregnant at time		Other (Specify)		ognanoy			ay rou
	the deary the ary the arched fo	Physiciar	Part II. Other significant conditions	9 Unknown	it not resulting in t	he underlying cause	aiven in Part I	. 23e. Dio	tobacco us	e contribute to	the cause of death?
	Records, P.O. Box 68 The law requires that the death certif cate has been signed by the attending page 2 should be detached for use as	d by		3					'es 2 🗸 N	No 3 Prob	ably 4 Unknown
	ords, v requir s been s should	Completed							opsy	prior to c	opsy findings available ompletion of cause of
	tal Records clan: The law requi certificate has been ector, page 2 should	omb							formed?	death? 1 ✔ Ye	s 2 No
	certification:	Be	25. Was case referred to medical examiner?	pital: 1 Innationt	2 ER/Outpa		Other	neck only one)	Dogidona	ce 6 🗸 Other	Sagna
	of Vide Physic Rer this seral dire	- L	1 Yes 2 No	28a. Date of Injury	28b. Time		jury at Work?	28d. Describ			. Scerie
O sign the second of the secon						1	Yes 2 No	0			
のマンガン 二 28e Place of Inju					/ - At home, farm,	street, factory, office	building, etc.	28f. Location or Town		Number or Ru	ral Route Number, City
	Hospita 24 hours Fuuera ely fille	Se	4 Homicide 29a Certifier 1 Certifying Physician		nowledge, death o	occurred at the time,	date and place	, and due to the ca	use(s) and	manner as start	ed.
	Divi To the Hospital or within 24 hours after To the Fuueral Dir	Medical	one) 2 Medical Examiner: 0			stigation, in my opinio	on, death occur		te and place	e, and due to the	e cause(s)
_		Σ	29b. Signature and title of certifier	86.00			29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 22, 2006				
			30 Name and address of person who cor	npleted cause of deat	th (Item 23a)						
_				stant Medical Ex	caminer 11	1 Penn Street,	Baltimore, I	MD 21201			
State 31. Date filed (Month, Day, Year) 37. Registrar's Signature Registrar MAY 0.3. 2006											
				-							

			1 - For State Registrar		Marylan		artment rtificate			and M		eg. No.	006		942
Н	Physici	an	1. Decedent's Name (First, Middle, Vonnie		reno						2 Date of Dea Month i1		Year		of Death
1	/Medic	al	4a. Facility Name (If not institution,				45 Ch. T.			(0)	APITI	30,		19:4	46 M
	Examir	er	Carroll Hospi		,		4b. City, To		inste	or.			ounty of Dea Carrol		
	Funeral			. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Birth (Month, Day Aug. 4,	1	9. Bir		e or Foreign
	Director		126-48-4595	1□M 2∏F	47	Yrs.	Months (Days	Hours	Min.	Aug. 4,	'195	8	thplace (State	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d Inside	City Limits
	Maryl f eho	ō	MD Carr	·o11		,,		neyt	own						es 2 No
	r 28a	rec	10e. Street and Number				10f. Zip C	ode			1	0g. Citize	n of What C	ountry?	
	th will	Funeral Director	80 Grand Drive					217	87				USA		
	ams arms	Iner	11. Marital Status	Armed For	dent Ever in U.	.S. 13.	Was Deceder	nt of His Cuban	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14	. Race - Am Black, Whi		,
9	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		2 X No		1 □ Yes 2]		Specify:		, , , , , ,	s		31ack	
9500-91212	filed within 72 hours after death with the Maryland Hygione. Hygione. Ither than 'natural', or Itams 23e or 28e-f ehow ent, Ite Medical Exertinal feathdilled at	ed b	15. Decedent's		ites:	16a Dece	dent's Usual (Occupat	tion			16b Kind	of Business	Andustry	
5	n 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	Acc E . \	(Give	kind of work DO NOT use	done du	iring most	of workii	ng				
7	giene giene er the	Com	12	College (1	-401 5+)	Der	ital As	sis	tant			Hea1	th Car	re .	
and	d be ental ked c	To Be (17. Father's Name <i>(First, Middle, La</i> Ira thomas McI								<i>(Fir</i> st, <i>Middle, l</i> Lizabeth				
Maryland	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship Mrs. Mary E. McI		other)	19b. Mailir 7410	ng Address (S Villag	Street ar	d. #2	or or Rura 2 Syl	/Route Number cesville	City or T	Town, State, 21784	Zip Code)	
Baltimore,	Pages 1 a nent of Hez int: If item iry or othe		20a. Method of Disposition 1. ☐ Burial 2 ☐ Cremation 3	☑Removal from S		Place of Dispo)				ition - City or		
<u>=</u>	permit. Pages Department of I Important: If its any injury or o once.		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	cîfy)	St.	Mark			- 1	/6/20	-		City,		
a n	Pen Impo		Drian L	Haigh	1						& CHAPE + (410)-		A (Box 1400	195)	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	omplications that cally one cause on ea	used the death	n. Do not ent	er the mode o	of dying,	, such as	cardiac o	r respiratory arr	est,		Approxin Interval E Onset ar	Between
7	Physician /Medical		disease or condition resulting in death)	a. H =	>CV ()								Minu:	109
	Examiner		Due to (or as a consequence of):												
		ner	Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Dies to (or as a nonsequence of):												
V	nd nd transii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.											
8/60,	certificate be executed rding physicien and ise as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequ	uence of);									
280	physicate sthe t	dical		d								_			
XOR	nding use as	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								23	d. Date of de	livery	
	death le atten ad for u	Physician/Med	in the past 12 months?	4☐Pregna	rth 2 ∐Fetal ant at time of de		Ectopic preg Other (spec						Month	Day	Year
r S	at the	hys	9 □Unknown	9□ Unkno											· · · -
ecords,	w requires that the death certifics been signed by the attending ph should be detached for use as t	Completed by I	Part II. Other significant conditions	s contributing to de	ath but not resi	ulting in the u	nderlying cau	se giver	n in Part I.			oaccouse es 2□	contribute to	othe cause of obably 4 (
ဂြွ လ	law rec as bee 2 shou	piete	Congestive 1	Heart	Faily	18					24a. Was a		24b. Were a	utopsy finding	gs available
	ilcian: The lav certificete has rector, page 2.	mo;									autops perfor 1 Yes		prior to death? 1 Yes	completion o	t cause of
Vital H	artifice ctor.	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on				
5	hysic this co	ဥ	Yes 2□No	1		ER/Outpatien		Other	4 🗆 1901		ne 5□Reside			cify)	
noi	nding P th. : After t e funera	ation:	27. Manner of Death Salatural 5 Pending 2 Accident investigal		f Injury h, Day Year)	28b. Time of Injury	28c	lnjury a Work? 1 □ Ye	at ? es 2 □ N		8d. Describe ho	ow injury o	occurred		
DIVISION	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could no 4 Homicide determine	280. Place	of Injury - At ho ig, etc. (Specif)	ome, farm, str	eet, factory, o	office		2	8f. Location (St City or Town	reet and i	Vu <i>mber</i> or R	ural Route N	umber,
_	spital nours a neral C	ai Ce	29a. Certifier 1☐ Certifying	Physician: To the	best of my kno	wledge, death	occurred at	the time	o, date and	d place, a	ind due to the ca	ause(s) ar	nd manner as	stated	
	n 24 t n 24 t he Fu pletely	edicai	(Check only 2 Medical Ex	aminer: On the ba and mann	sis of examina	tion and/or in	estigation, in	my opii	nion, deat	h occurre	d at the time, d	ate and p	lace, and due	to the cause	e(s)
	To t	Σ	29b. Signature and title of certifier	1	1			icense					signed (Mont	,)
,	1		1 100 11	M	Y		10	00	5192	4	W	lay o	2,20	06	
	N		30. Name and address of person who Herbert P. Herbert	Son Sow		23a) (Type,	Print) Inchest	41	21	ıM.	duche c	14,	mi	1 211	02
	Sta	te	31. Date filed (Month, Day, Year)	· · · · ·	egistrar's Signa			t	-	h = f c	.,	- 3 (-	V - V 1	, , , , ,	
	Registr	ar	MAY 0 3 200	6	as At.	14000									

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

CHARREUE

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			1 - For State Registrer	State	of Marylar				lealth a Death	and M		giene () Reg. No.	06	13944	
	Physici	an	Decedent's Name (First, Middl	e, Last)			,	4			Date of Dea Month	ath Day	Year	3. Time of Death	
	/Medi		LEDNARD			N	ow	CKI	•		MAY	2,	2000		Α
*	Examir		4a. Facility Name (If not institution	n, give street and n	umber)	-	4b. City.	Town, or	Location of	Death	/		inty of Death		
			STELLA M	ARIS_	HOSPI	100			LONI					rimore	
	Funeral Director		5. Social Security Number 217-01-4919	6. Sex 1Д M 2□ F	7. Age (In yrs.	. last birthday) 9 Yrs.	Months	Days	II Under: Hours	Min.	8. Date of Birt Month, Da Nov Z	y, Year)	Cou	place (State or Foreig untry) MARY/AN	n
	pu *]	Usual Residence of Decedent 10a. State 10b. County	,	10c. C	ity, Town or Lo	ocation					_		10d. Inside City Limits	s
	anyla • ho	7	M		1	BAH								1 (√Yes 2 □ No	
	28a-1	ect	10e. Street and Number			DAT		p Code		-		10g. Citizen	of What Cor	intn/2	_
	with with	ä		K Str			101. 21		122	ı.L			4.5		
	ne 23	Funeral Director	11. Marital Status		cedent Ever in U	J.S. 13.	Was Dece				cify Yes or No Rican, etc.)		Race - Amer		_
10	ther of the control o	I	1 Never Married 2 Mar	ried Armed I	2 ☑ No	1	_	-		i, Puerto F	Rican, etc.)		Black, White	, etc.	
030	e sun	<u>م</u>	3 ⊠Widowed 4 □ Divorced	If Yes, G Year or	Dates:		1 🗆 Yes	2)XI No	Specify:			Spe	ecity:	hite	
5-0036	72 hours after death with the Maryland natural", or tterne 23a or 28s-1 ehow dical Examinar must be restilled at	Completed	15. Deceder (Specify only highe	nt's Education	d))	16a. Dece	dent's Usu	al Occupa	ation during mos	t of workin	ia .		f Business/l		
21	within ene. then "	npidu	Elementary/Secondary (0-12)		(1-4or 5+)				during most				-4	of Balto	
21	filed w Hygier ther th	ပိ	7+4			<u> </u>	hAi	ノブラ	eu		(Fine 14:4.1)			Council	
Pu	lid be fill Sentat H rked ott	Be	17. Father's Name (First, Middle,	Last)		A)	· \			V A	(First, Middle,	1		101.	
3	should nd Men marke amaric	욘	relix	Lie (Time Date)		10000	ICK	(C)	- / -	· · ·	Route Numbe			WSKI	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mental Hyglene. Item 27 is marked other then "natural", or teme 23s or 28s-1 show other traumatic event, the Medical Eventian must be notified at		19a. Informant's Name/Relations	-con - da	مماطعيا							I II	MI, State, 2	ip code)	
	1 an Heel em 2		20a. Method of Disposition	JON - UN	20b.	Place of Dispo	osition (Na	me_ol			ate	20c. Locati	on - City or 1	Town, State	_
õ	80 = 5		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State 🗻	cemetery, crei AKLNW	matory or	other plac	(a)	10:50	0/	Ball	il sa are	MARYLM	1.
Baltimore	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service		Ο,		2. Name a	nd Addres	ss of Facilit	y y	2006	TOF		n House	س
Ba	Depa Impo eny i		+ Abarle	12 an	م	-	J050	ph	N. 2	ANI	Stre	of Bi	alte.	AL HOME MD ZIZZ4	L
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that	t caused the dea	ith. Do not ent	ter the mo							Approximate Interval Between	
	Physician	ė I	Immediate Cause (Final disease or condition	/	ENTIA									Onset and Death	
	/Medical		resulting in death)	a	o (or as a conse	quence of):									_
	Examiner		Sequentially list conditions,	b											
	ъ 	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	quence of):									
,	requires that the death certificate be executed een signed by the ettending physicien and nould be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a conse	quence of):									-
8760,	icate be ex physicien s the buria	ical E			0 (0) 43 4 001130	quo.100 01).									
687	phys phys s the			d											
×	eath certific ettending p	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c	utcome of pregn	nancy						23d.	Date of deli	verv	
Вох	Jeath etter	clar	in the past 12 months?		birth 2 Fet gnant at time of		□Ectopic p □ Other (s					10	Month	Day Year	
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	res thet the de signed by the e I be detached f	by Physician/Med	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	ındərlying	cause givi	en in Part I.		23e. Did to	obacco use d	contribute to	the cause of death?	
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isi	Attending r death. sctor: Atter	icat	3 Suicide 6 Could		ce of Injury - At h	nome larm st			103 2 []		81 Location /	Street and N	umber or Ru	ral Route Number,	_
Division	lor A after Direct	Certification:	4 ☐ Homicide determ	buil	lding, etc. (Speci	ify)	rcot, ractor	y, 011100			City or Tox				
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical	ng Physician: To the Examiner: On the	basis of examin	owledge, deat ation and/or in	th occurred	at the tin	ne, date an pinion, dea	d place, a th occurre	nd due to the	cause(s) and date and pla	manner as	stated. to the cause(s)	
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certific		anner stated.		29	c. Licens	e number			29d. Date si	gned (Month	, Dey, Year)	_
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	2		30. Name and address of person	who completed	use of death the	m 23a) (T	Print\	ン	15/	25		2/	700	<i>ي</i>	_
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	St	ate	31. Date filed (Month, Day, Year		DULANE Registrar's Sign		EI KU	. 1	TMONT	UM, I	Ф 2109	د.			
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MAY 2, 2006 6:25 a.m.

LEONARD NOWICKI

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Manouchehr Pishdad 5:52 p April 26, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore** Gilchrist Hospice Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□**火** 2□ F 81 Yrs 218.94.6619 Director May 30, 1924 Iraq Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 🕱 No Director Maryland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 20794 9950 Guilford Road; #302 Iran 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ **X**o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) entertainment studio College (1-4or 5+) Elementary/Secondary (0-12) Managment unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) I and 2 should be lealth and Mental Mahmoud Pishdad Badrieh Badie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health 11601 Dark Fire Way Columbia, Maryland 21044 Ms. Setareh Shemali Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 Durial 2 Cremation 3 Removal from State 04/28/2006 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Slack Funeral Home, P.A unlitten 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Belween Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) months Physician Y /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit Due to (or as a consequence of) Physician/Medicai as signed by the attending 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Minknown page 2 should Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No hes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d, Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 2 Accident 5 Pending 1 Tes 2 No death. the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d filled in by 4 Homicide 100 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier April 27, 2006 of person who completed cause of death (Item 23a) (Type, Print) Balto Md 21204 K. Charles St. GBINC 6701 (0

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0

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Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O.

MANOUCHER

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32. Registrar's Signature

		í	For State Registrar	State of Maryla		artment of rtificate of			giene () () 6	13947
Н	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic			Men				April		2004	5:30 PM
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	Funeral		5. Social Security Number 6. S	¬x 2□ F 70	rs. last birthday) Yrs.	Months Day		frs. 8. Date of Birt lin. (Month, Day June 29	v, Year)	Cour	lace (State or Foreign itry) 7 York
	Director		116-28-7555 Usual Residence of Decedent	XX / / / /				Julie 29	, 1933	INGA	/ IOIK
	yland 10W	Ì	10a. State 10b. County	10c. (City, Town or Lo	ocation				1	0d. Inside City Limits
	Mar-fat	to	MD Prince G	eorge's 1	Laurel						1∰Xes 2□No
	th the	j.	10e. Street and Number			10f. Zip Code)		10g. Citizen of		itry?
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36	be filed within 72 hours after death with the Maryland lal Hygiane id other than "naturel", or Items 23s or 28s-f show event, the Modical Examinar must be coeffied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2🛣 🔏		(Specify Yes or No- lerto Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y: Whi	etc.
ŏ	2 hou		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Dcc	upation		16b. Kind of B		
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Maryland	12 should be and Mental 18 marked reumatic ev		19a. Informant's Name/Relationship (** * *				Rural Route Numbe	-		Code)
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0	ges if of the		20a. Method of Disposition 1 ∑∑§urial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory`or other p				-	
altimore,	t. Pa rtmen rtant:		4 Donation 5 Other (Specify	<u> </u>		L Cemete		28/2006	Laurel	, Mai	утапо
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: if item 27 is marked any injury or other traumatic e.		21. Signature of Funeral Service Licen					l Home, P ue Laure		land	20707
			23a. Part1. Enter the disease, or own shock, or heart failure. List only	olications that caused the de one cause on each line.	eath. Do not en	er the mode of d	ying, such as card	diac or respiratory ar	rest,		Approximate Interval Between
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Ġ.	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):						
В	LAdminer	Ļ	Sequentially list conditions,	b. Due to (or as a cons	courses of					_	
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Box	The law requires that the death centificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pred 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	Ectopic pregnar Other (specify)				ite of delive onth	ory Day Year
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ā	iclan: Th certificate rector, pag		25. Was case referred to medical				26 Place of I	1 ☐ Yes Death (Check only o		1 🗌 Yes	2) 2 (No
<u> </u>	ysick is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2	☐ ER/Outpatie	nt 3 DOA)ther	g Home 5 ☐ Resid		ner (Specif	()
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	omple	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)
	r > P* 0		Alla.	Z MO		- N	00636	53	April	28,	2006
	1401		30. Name and address of person who	completed cause of death (In	tem 23a) (Type,	Print)	11 5350	cel.1.	COV	OMRI	A, MO 21044
	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's Sig	mature	el rugar	F \	3	TO LO		. 1
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			For State	State of Ma	ryland / I	•	tment of H <i>ficate of l</i>		-	Com	000	13948
			Registrer 1. Decedent's Name (First, Middle, Last)		0011	nouto or i		2. Date of De			3. Time of Death
	Physici: /Medic		Sharon		Ro	yal			April	Day 20		
	Examin		4a. Facility Name (If not institution, give				-	Location of Death		4c.	County of Dea	ath
			University of Marylo 5. Social Security Number 6. Se		(In yrs. last bi		If Under 1 Year	It Under 24 Hrs.	8. Date of Bir	rth.	N/	tholace (State or Foreign
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	ehow	7	10a. State 10b. County		10c. City, Tow		tion					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	MD Boltimo	re	Dino	lalk	10f. Zip Code			10a. Citi	izen of What C	
	3a or		7817 E. Collingham	Daire Ant	C		212	23		-	JSA	,
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Baltimore,	es 1 and 2 of Health fitem 27		20a. Method of Disposition	-	20b. Place o	of Disposit	ion (Name of tory or other place	6)	Date	20c. Lo	ocation - City o	2 1238 r Town, State
Ē	Pages nent of ant: If It ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		King	Por	K Cene	ery 05-0	6-06	Rang	dallston	on, MD
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of \	Physician: this certificant	2	T Tes 218 NO	Hospital: 1 SInpatie		_	3 DOA Oth	4 Nursing H	ome 5 Resi			ecify)
	ing After une	tion	27. Manner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		Time of Injury	28c. Injun Worl	Yes 2 □ No	280. Describe	now injur	y occurred	
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	- 3 - 8		1 Jun 831	Sutto	n, MD		PI	3809	50		-	29,2006
	6		30. Name and address of person who co				int)					
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State of Maryland / Department of Health and Mental Hygiene 1115

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	aryland •how		10a. State 10b. Cour	nty		10c. City, Town	or Location					10d. Inside City Limits
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	e filed Il Hygi other	Be C	17. Father's Name (First, Midd	le, Last)			OWITCI		18. Mother's Nam	e (First, Middle,	Maiden Sumame)	on company
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, S	ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If Item 27 Is marked other than or other treumatic event, II a M		Jeanne J. 20a. Method of Disposition	Reimulle	er Wi	20b. Place of	Disposition	(Name of	orest Cou	rt #106 Date	20c. Location - City of	n, Maryland or Town, State
LIMUL more, Mai	ages ant of ht: If It y or o		1 Durial 2 ☐ Crematic	n 3 □Remova	al from State	Dulan	ey Val ey Val rial (ley	^{ce)} ¦ s May 5	2006	Timonium	Maryland
Athmuller, Baltimore, Maryland	permit. Pages Depertment of Important: If I eny injury or one		21. Signature of Fundal Servi			Memo	22. Nam	and Addre	ess of Facility Ru		on Funeral	Home, Inc.
, m	Depermonent Deperm	J.	1 Tank W	Hogan			1050) York	Road	Towson,	Maryland	21204
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.O. B	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transi	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4[Pregnant at ti			r (specify)	,		Month	Day Year
<u>α</u>	that the		Part II_Other significant cond	litions contributi	ng to death but	t not resulting in	the underly	ing cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires been sign should be	Completed by	CAD I Scher	nic car	diomy	spathy,	enast	ige re	inal	1 🗆 Y	′es 2□No 3□F	robably 4 Unknown
900	e law re has bee je 2 sho	piet	disease HTN	Type	II DIN	setes 1	hronic	: bue	Kpain	24a. Was	an 24b. Were a	autopsy findings available
Œ.	The l	Com	S/C MVC	, ,,		,			, ,	perfo	rmed? death? 21 No 1 ☐ Ye	completion of cause of
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to med examiner?	ical Hospita	1: /			0#	26. Place of Death			
of	Phys r this ral dir	To :	1 ☐ Yes 2 ☑ No 27. Manner of Death		. Date of Injury (Month, Day		ime of	DOA 28c. Injur	4 🗆 14d15illig 114		dence 6 Other (Sp	ecify)
ion	Attending Physician: r death. sctor: After this certifics by the funeral director, I	atior	1 Natural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(Month, Day	Year) li	njury M		rk?]Yes 2 □ No			
Division of Vital Records,	or Attender der Olrecto	Certification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ald not be ermined 286	. Place of Injur building, etc.	ry - At home, fa (Specify)	rm, street, fa	ctory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
	Hospital	ai Ce	29a. Certifier Certif	ying Physician	To the best of	my knowledge	, death occu	rred at the ti	me, date and place,	and due to the	cause(s) and manner a	as stated.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medic one)	al Examiner: O	n the basis of e nd manner state	examination an	d/or investiga	ation, in my o	opinion, death occur	red at the time,	date and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of cert	fier	-		,	29c. Licens	se number	4	29d. Date signed (Mor	ith, Dey, Year)
	V		20 Alone - A	INOL		ath (Itam 22-)	Territo Delen	DOOR	וטומ		5-2-0	6
1		3	30. Name and address of pers	on who complete	CAUSE OF DE	GUN G	Tank	linsa	quare 1	rive	Balto. 1	MD 21237
	Sta		31. Date filed (Month, Day, Ye		32 Registrar	r's Signature	BORNEL	2	v			
2.	Regist	rar	MAY U	3 2006	J. S. J. S. S.	1 100						

DHMH 17 Rev 1/2001

	Please	Type or Print in Black i			•
	1_ For State		partment of Health and I	Mental Hyglei	P nna 13950
A 7. 4.	Registrar amend Item 1. Decedent's Name (First, Middle, La	#26 Per Verb G855	3763708 Officeau	Reg. 2 Date of Death	No. 3. Time of Death
Physician				Month	Day Year
/Medical	Joseph Grover 4a. Facility Name (If not institution, gir		4b. City, Town, or Location of Death		30, 2006 06:50 A M
Examiner	Upper Chesapeake		Bel Air, Maryla		Harford
Funeral	5. Social Security Number 6.	Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.		
Director	212-40-2967	1X M 2 F 64 Yrs.	Months Days Hours Min.	02/08/194	Maryland
pug &	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location		10d. Inside City Limits
Aaryle 1 sho	,				1 ☐ Yes 2X No
O C S S 336 J36 J36 J36 J1: or items 23s or 28s-1 si cominer must be noutlined by Funeral Director	10e, Street and Number	.u raiisto	10f. Zip Code	10g.	Citizen of What Country?
S with	2804 Pleasantvi	lle Road	21047		J.S.A.
Geatt Geatt	11. Marital Status	· · · · · · · · · · · · · · · · · · ·	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
Se after or its	1 ☐ Never Married 2 X Married	1 TVVAs 2 No	1 ☐ Yes 2 ☑ No Specify:	o riicari, etc.)	Black, White, etc. Specify:
1215-0036 within 72 hours after death with the Maryland ene. than "natural; or items 23s or 28s-1 show he Madical Examinar must be notified at empleted by Funeral Director	3 Widowed 4 Divorced	Year or Dates Conflict			White
n 72 h	15. Decedent's E (Specify only highest gr	ade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of wor b. DO NOT use retired)	kina	. Kind of Business/Industry ommercial and
id 21215-00 id 21215-00 id 21215-00 id 21215-00 id 21215-00 id 2121212 id 212	Elementary/Secondary (0-12)	College (1-4or 5+)	f-Employed		dustrial Construction
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SO/O arylanc should be and Mental marked o	Joseph Grover Ra	avman, Sr.	Mary S	orochak	
Maryland 21215-0036 at 2 should be filled within 72 hours aff tilth and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Madical Exam. To Be Completed by F	19a. Informant's Name/Relationship	_	ailing Address (Street and Number or Ru		ty or Town, State, Zip Code)
TH30/06 Tre, Maryland 212 s 1 and 2 should be filed within freath and Mental Hygiene. Item 27 is marked other than other traumatic event, than To Be Comp	I. Nancy Raymar	n (wife) 2804	Pleasantville Roa		
Baltimore, vernit. Pages 1 ar Department of Hea important: if the important: if the interpretation of the bister.	20a. Method of Disposition 1 Daurial 2 Cremation 3		position (Name of rematory or other place)	Date 20c	Location - City or Town, State
altimor mit. Pages partment of content: if it	4 Donation 5 Other (Speci	(fy) Gardens	of Faith Cem. 05/0		
Ball Permil Depart Impor	21. Ignature of Funeral Service Lice	. () (n Funeral Home, P.A.
	23a Part 1 Enter the disease or con	nplications that caused the death. Do not			le, Maryland 21087 Approximate
	shock, or heart failure. List only Immediate Cause (Final	one cause on each line	· -		Interval Between
Physician / /Medical	disease or condition resulting in death)	a. Due to (or as a consequence of):	nary arter	y our	1 mounts
Examiner		Holen	nosclesosis		1.03405
Je Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			0,-
5), executed nn and i'al-transit Examiner	Cause (Disease or injury that initiated events	c			
		Due to (or as a consequence of):			
876 876 Sete b cete b	•	d			
Vital Records, P.O. Box 68760, sicien: The law requires that the death certificete be executed certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit be Completed by Physiclan/Medical Examila	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery
Bo Bath attent of an Ifor u	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
O. O. the d	9 Unknown	9 Unknown	//		
S, P	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ords:	Hyperie	ensian		1 ☐ Yes	2 No 3 Probably 4 Monknown
Deco				24a. Was an autopsy	24b. Were autopsy findings available
The The page				performed	
/ita	25. Was case referred to medical examiner?	Line a ideal.		th (Check only one)	
Physical direction of T.	1 Yes 2 16	Hospital: 1 Inpatient 2 ER/Outpat			6 Other (Specify)
OLD OIN Gling Hiner funer funer	1 ☑Natural 5 ☐ Pending	(Month, Day Year) Injur		28d. Describe how in	njury occurred
Division of Vital Recomplication of Vital Recomplication of Vital Recomplication of Vital Recomplication of Vital Recomplication of Vital Recomplication of Vital Recomplication of Vital	3 ☐ Suicide 6 ☐ Could not I	28e. Place of Injury - At home, farm,		28f. Location (Street	t and Number or Rural Route Number,
Signature din bit	4 Homicide	building, etc. (Specify)		City or Town, St	tate)
Haayman Joseph Division of Vital Rec To the Hospital or Attending Physicien: The law within 24 hours after death of the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2.3 Medical Certification: To Be Compl	29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, de	ath occurred at the time, date and place	, and due to the cause	e(s) and manner as stated.
the Hosp thin 24 hours on the Fune impletely fill	(Check only 2 Medical Exa	miner: On the basis of examination and/or and manner stated.		rred at the time, date	and place, and due to the cause(s)
Divisio Divisio To the Hospital or Attendi within 24 hours atter death. To the Euneral Director: Acompletely filled in by the fu	29b. Signature and title of certifier	Atha 1' =	29c. License number		Date signed (Month, Day, Year)
(4	, MM	- Httending	D. 16440	4 (-)	YRIL 30 W 2 006
30	111-0-1	o completed cause of death (Item 23a) (Type	002.5. Ataly	and Ran	PRIL 30th 2006 d. Belais 21014
State	31. Date filed (Month, Day, Year) MAY 0 3 20	32. Registrar's Signature	P AT	val nucle	4, 5400 2007
Registrar	MAY 0 3 20	106 May to A			

DHMH 17 Rev 1/2001

			For State Ragistrar	State of M	arylan	d / Depa		of H	ealth a	and M		9	6	13951
			Decedent's Name (First, Middle	lle, Last)	_				-		Date of Deat Month	h Day	Vasa	3. Time of Death
ж	Physici /Medic		Kuth		Su	llivar	\				APRIL		Year	01:45 AM
	Examin		4a. Facility Name (If not institution	on, give street and number)				Town, or	Location o	of Death		4c. County		
			2707 Gray Mand	or Ct.				Dund	dalk			B	altir	More
	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs.	last birthday)	If Under		If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day,			place (State or Foreign
	Director		219-22-5761	1□M 34□F	7.7	Yrs.	WOTHING	Days	riours	101111.	Jan. 18			ryland
	p ,		Usual Residence of Decedent 10a, State 10b, County		100 Cit	y, Town or Lo	4'							
	anyla shov	-	10a. State 10b. County	,	100. 011	y, TOWN OF LO	cation							10d. Inside City Limits
	Ba-f	ctc		Baltimore					Du	ndal				1 Yes 2 No
	or 2	Director	10e. Street and Number				10f. Zip	Code			10	og. Citizen of N	What Coul	ntry?
	ath v		2037 Jasmin						2122			United		
	er de Items	Funeral	11. Marital Status	12. Was Decedent Armed Forces?)	.S. 13.	Was Decede f Yes, speci	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	can Indian, etc.
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	No		1 ☐ Yes 2	₩ No	Specify:			Specifi	<i>/</i> :	
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an	d be antal ced c	To B	Louis Novotny	V					E1:	sie i	M. Graf		,	•
2	shoul nd Me mark mati	F	19a. Informant's Name/Relations			19b. Mailir	a Address	(Street a			I Route Number,	City or Town	State Zir	Codel
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Brownstatt: If them 27 is marked other than "natural," or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examment must be indiffice at once.		Mrs. Nancy Ma		ter)						Dundalk		. ,	21222
ė,	1 an Heal em 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nam	e of	1			20c. Location -		
Baltimore,	ages nt of t: If it		1 ☐ Burial 2 🎛 Cremation		C	emetery, crer	natory or oth	her place	·	~ / ^ /	- 1			
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			Mile C. Je	and lineting that areas	d the death		922 W	ise	Ave.	Du:	ndalk, M	arylan	3 21	222
Н,		. 12	234. Part1. Enter the disease, or shock, or heart failure. List	t only one cause on each li	ne.	i. Do not em	er the mode	or dying	, such as	cardiac o	ir respiratory arre	St,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):								
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۵.	res that tigned by	/ Ph	Part II. Dthar significant condition	ons contributing to death b	ut not resi	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco use cont	ribute to th	ne cause of death?
ds,	sign sign d be	d by	DEEP VENOUS T				` `				1 ☐ Ye	2 No	3 ☐ Prob	ably 4 Dunknown
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E C	rding Phy th. : After this funeral o	lon	27. Manner of Death 1 Natural 5 ☐ Pendin		y Year)	28b. Time of Injury		c. Injury Work			28d. Describe ho	w injury occurr	ed	
S	death.	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be			М	-	es 2 🗆 N					
Division of Vital	or Al	Certification:	4 Homicide determ		c. (Specify	me, farm, stri	et, factory,	office		2	28f. Location (Str. City or Town,	eet and Numb State)	er o <i>r Hur</i> a	I Route Number,
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7	ſ		1 miles	1100 08				62	232		Λ	MY O	1 2	006
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1			The Tobal Hos	Kine Ha	xet.	2/	64	11 in	1000			I	ĪΑ		
	Funeral		5. Social Security Number 6. Sec		(in yrs. last	birthday)	If Under		If Under		8. Date of Birtl (Month, Day	1 ,	9. Birth	place (State or Foreign	_
	Director		246-66-2847 ^{1□}]M 2[X]F	63	Yrs.	Months	Days	Hours	Min.	(Month, Da) 8–20-		Con	N.C.	
	P.		Usual Residence of Decedent												_
	larylan ehow	_	10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits	
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36	or l	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give	D		1 🗆 Yes 2		Specify:		,		ify: Bla		
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f ehow the Medical Examer must be positive at	d b	3 Widowed 4 Divorced	Year or Dates:). DIC		
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e e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Itams 23a or 28a-f ehow amy injury or other traumatic event, the Medical Examination to totifical at ODGs.	1 3	20a. Method of Disposition				sition (Nam		ī		ate	20c. Location			_
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Ħ	t. Pertrant		'4 □ Donation 5 □ Other (Specify)		Gree		int Ce			5-2-(Baltin			_
Bal	Depa Impo any ir		21. Signature of Funeral Service License	1 7	1		. Name and March					imore, E. Nor		21202	
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=		Co									perform 1 Tes	ned? 2 ☑ No	death?	2 No	
/ita	Phyeician: this certific ral director,	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or	10)			
of \	Phyei this c al dire	2	1 No H	ospital: 1 Inpatien		Outpatien	t 3 🗆 DO	A Other	. 4 □ Nui	rsing Hom	ne 5 🗆 Reside	ence 6 🗆 O	ther (Specia	fy)	
П		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 281	 Time of Injury 	28	Bc. Injury : Work?	at ?	2	8d. Describe h	ow injury occu	rred		
Sio	Attandi death. ctor: A y the fu	ati	2 Accident investigation				М	1 🗆 Y	es 2 🗆 1	٧o					
Division	l or Att after d Diract J in by I	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home (Specify)	, farm, str	et, factory,	office		2	8f. Location (Si City or Town		ber or Rura	al Route Number,	
	ital or irs afte ral Dir led in	Ce		1											
	t hout fune fune	edicai	29a. Certifier 1 Certifying Phys	sician: To the best of	my knowled	dge, death	occurred a	it the time	, date and	d place, a	nd due to the c	ause(s) and m	nanner as s	stated.	
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	led	une)	and manner state	ed.										
	To To	Σ	29b. Signature and title of certifier					License				9d. Date sign	1	-	
			· with					KE	5-	00	0 /	UR. 1	27	2006	
	2			mpleted cause of dea	ath (Item 23	a) (Type,	Print)	-	/ /	, ,	1	10	/	/	
)		Robin Veidt	60	20 1	1- W	10110	51	· B	111	more	MALS	1/4/1	2006	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Acce	and the					/			
	Registr	all	MITA II 9 COOR	A SECTION OF THE PARTY AND ADDRESS OF THE PART	6	1	-7								

			For State Registrar	State of N	Maryland / Depa	artment of H		Mental Hyg	iene 93. No. 200	06-1	13953
	Physici	an	Decedent's Name (First, Midd	lle, Last)			-	2. Date of Death Month	h	Year	3. Time of Death
	/Media	cal	Nellie Sess 4a. Facility Name (If not institution		rel .	4b. City, Town, or	Location of Dogsth	4	4c. County of	-	21:30 PM
	Examir	ner	rand to a second to the second	. •		Δ.	nore	'.	4c. County (or Death	
	Funeral		Johns Hopleins 5. Social Security Number	6. Sex 7. A		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplac	e (State or Foreign
	Director		213-36-1523 Usual Residence of Decedent	1 M 2784,F	68 Yrs.	Moranto Sayo	1,00.0	01,13,	1938	M	
	/land		10a. State 10b. County	<u> </u>	10c. City, Town or Lo	ocation				10d.	Inside City Limits
	ours after death with the Marylan rel', or items 23a or 28a-f show Examiner mast be ne lifted at	ctor	MD N	JA .	Baltimore						XXYes 2□No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country	?
	s 23a	ral	4320 Clareway A	Apt 5_E 12. Was Deceder	t Suprin 11 S	212				S.A.	Indian
	fler de ritem iner	Funeral	11. Marital Status 1 □ Never Married 2 □ Mar	ried 1 Tes 2X	5? JNo	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		, White, etc	
5-0036	rel', o	þ	3 Widowed 4 □ Divorced	If Yes, Give		1 ☐ Yes 2Ã No	Specify:		Specify:	Blac	ck
5-0	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-1 show Is Madical Examiner must be notified at	Completed		nt's Education est grade completed)	(Give	dent's Usual Occupa kind of work done d	luring most of work	king	6b. Kind of Bus	siness/Indus	itry
2121	within ene. then	Jup	Elementary/Secondary (0-12) 8th grade	College (1-4o	r 5+)	DO NOT use retired) Nurse)		Private	e Duts	7
	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, the Ma	Be Co	17. Father's Name (First, Middle,			I I I	18. Mother's Nam	e (First, Middle, N			
/lan	ould be Mental arked o	ToB	Frederick Vaug	ghn			Lillian	McCullou	gh		
Maryland	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 is marked other then "natur or other treumatic event, Its M. AICAI		19a. Informant's Name/Relations	ship (Type, Print)	19b. Mailir	ng Address (Street a	ind Number or Rui	rai Route Number,	City or Town, S	State, Zip Co	ode)
	permit. Pages 1 and 3 Department of Health Importent: If Item 27 any injury or other tr. once.		Indie Sessoms-I	Daughter	2960 20b. Place of Dispo	Mallview	Road, Ba		Md 21		State
Baltimore,	Pages nent of I nnt: If it		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5				1			•	
altir	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service		Baltimore	National Ron F/H W		/2006 1	Baltimo:	re, Mc	1
ä	Depared Important		Times	tto K-9	me 43	rcn fyn w 00 Wabash	est Ave, Ba	ltimore,	Md 21:	215	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cause t only one cause on each	ed the death. Do not ent line.	er the mode of dying	, such as cardiac	or respiratory arre	st,	In	pproximate terval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	-a Arry	hmia					O.	nset and Death
1	/Medical Examiner		resulting in dealth)	Due to for a	is a consequence of):						
		-er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):						
1	cuted nd ransit	Examiner	cause. Enter Underlying	C							
,0928	ate be executed thysicien and the burial-transit	I Ex	resulting in death) Last	Due to (or a	s a consequence of):					1	
687	phy s the	dicat		d							
Box (eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Je			23d. Date	of delivery	
	the atte	sicia	in the past 12 months? 1 Yes 2 No			Ectopic pregnancy Other (specify)			Mon	th Da	y Year
P.0	that the ded by the detached	Phy	9 Unknown		but not societies in the cu		n in Dani I	22a Did tob	acco use contril	buta ta tha a	nouse of death?
ds,	ires tha signed d be det	1 by	End - Stage Re		-	nderlying cause give	nın Parti.			3 ☐ Probabl	
of Vital Records,	w require been sig should b	Completed by	one stage in	<u> </u>			· · · · · · · · · · · · · · · · · · ·	24a. Was an		ore autoney	findings available
Re	The lav	dwo						autopsy perform	ed? de	ior to compleath?	etion of cause of
ita		0	25. Was case referred to medica	ıl			26. Place of Deat	1 Yes 2.			2110
<u>></u>	lis diri	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 Inpai			4 🗆 Indianing File	ome 5 Resider	nce 6 Other	r (Specify)	
nc Onc	ling Ph	iuo	27. Manner of Death 1 ☑Natural 5 ☐ Pendir		jury 28b. Time of Injury	Work		28d. Describe how	v injury occurre	d	
Division	of or Attending F after death. Director: After d in by the funera	ficat	2 Accident investi	not be age Bloco of It	njury - At home, farm, str		es 2 □No	28f. Location (Stre	eet and Number	r or Rural R	oute Number,
Ω	a after	Certification;	4 Homicide	building,	etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,			
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical (29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the bes Exeminer: On the basis and manner s	of examination and/or inv	n occurred at the time vestigation, in my opi	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and man te and place, ar	ner as state nd due to the	od. e cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifie	al		29c. License	number		d. Date signed	,	v, Year)
•			Pat Kel	ly M.		P196	27		4/11/	06	
	1		30. Name and address of person	27			212.51				
V.	Sta	te	PAT Kelly, 49 31. Date filed (Month, Day, Year)	140 Eastern 32 Regis	trar's Signature	iere, MU	21201				
	Registr	ar	MAY 0 3	2006	A April	di					

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APR12 **Physician** Year 6:23 PM RACHFI 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month. Day Year)

2-06-1932 Bon Secours 5. Sociaf Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 X F 74 Yrs. Director 212-30-6326 Maryland Usuat Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location rthen "natural", or itema 23a or 28a-f ehow the Medical Exprementatible notified at 10d. fnside City Limits NA 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1601 W. Mulberry Street Funeral 21223 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 XNever Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Pages 1 and 2 should be filed vitner of Health and Mental Hygie trant: if item 27 is marked other tylury or other traumatic event. Domestic 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Ruffin Jenny Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Smith/ Daughter 1601 W. Mulberry Street Baltimore, MD 21223 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o important: if any injury or once. 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery 05- 01-06 Lansdowne, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jones meda Wylie Funeral Home 638 N. Gîlmor Street Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PROBABLE MYDLARDIAL /Medical Due to (or as a consequence of): Examiner ARTERIOSCZEROT MNENUNN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed physicien and s the burial-trans PZUERA2 Physiclan/Medical use as I attending p IF FEMALE: 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year 4☐ Pregnant at time of death Day signed by the a 5 Other (specify) Ö ۵. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ate has been significated be page 2 should be LUNG DISEASE UBSTRACTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CEREBRA- VASCULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. fnjury at Work? ospital or Attending Phours after death.
Ineral Director: After ty filled in by the funera After t 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 2 Accident 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours af To the Funeral D completely filled it 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 23300 APRIL 27 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130N SELOURS HOSP, 2000W BARTO STI BALTO M.D. 21223 SUDMIR. D. 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State o	•	eartment of Health a	, ,	giene	13955
	Dhysic	ian	1. Decedent's Name (First, Mid	ldle, Last)			2. Date of Dea Month	nth Day Year	3. Time of Death
	Physic /Medi Examii	cal	Roland Birger 4a. Facility Name (If not institut		nber)	4b. City, Town, or Location of	04	30 2006 4c. County of Deat	
1			235 Bridge Dr	rive		Joppa		Harford	
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. last birthday	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day		hplace (State or Foreign buntry)
	Director		079-26-8366	IAN ZUF	72 Yrs.		01/21/1		w York
	and w		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c. City, Town or L	ocation			10d. Inside City Limits
	ahow	ō							1 ☐ Yes 2 No
	the M 28e-f	Director	MD Har	ford	Joppa	10/ 7: 0 1			
	with	급				10f. Zip Code		10g. Citizen of What Co	untry?
	eath w	era	235 Bridge D		dent Ever in U.S. 13	21085	-:-2/2	U.S.A.	
36	hours after death with the Maryland tural, or Items 23a or 28e-f show at Everst on trunk be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 💆 Ma 3 □ Widowed 4 □ Divorce	Armod For	oces? 2 \(\text{No} \) e Korean ates Conflict	Was Decedent of Hispanic Origin Yes, specify Cuban, Mexican 1 Yes 2X No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	n 72 hours *natural; edical Eva	edit		ent's Education		edent's Usual Occupation		16b. Kind of Business/	ite
15		Completed	(Specify only high	est grade completed)	(Giv	e kind of work done during most DO NOT use retired)	of working	100. Kind of Business/	industry
12	iene.	E	Elementary/Secondary (0-12)	College (1	-4or 5+)	chinist		Ray's Enve	lone Co
	2 should be filed with and Mental Hygiene ta marked othar tha aumatic avant, the	BeC	17. Father's Name (First, Middle		T Plan		r's Name (First, Middle,		Tope Co.
an	ld be lental ked ic av	To B	Birger Thune			Olan	Bleid		
Maryland	shound M	-	19a. Informant's Name/Relation	nship (Type, Print)	19b. Mail	ing Address (Street and Numbe		r. City or Town, State, 2	in Code)
Š			Rebecca H. T	hune (wife		Bridge Drive -			
<u> </u>	r Hearlitam	1 5	20a. Method of Disposition	iimie (wile	20b. Place of Disp	osition (Name of		20c. Location - City or	085 Town, State
9	ages ant of nt: If if		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		state	matory or other place)	05 /02 /2006	D- 14 '	
Baltimore	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other to once.		21. Signature of Funeral Service		Metro Cr	ematory, Inc. (2. Name and Address of Facility	U5/U2/2006 I	baltimore,	Maryland
B	permit. Departr Importu any inju		1000	Land.		750 Belair Roa			
			23a. Part 1. Enter the disease,	or complications that ca	sused the death. Do not er	iter the mode of dying, such as o			Approximate
	Discordados.		shock, or heart failure. Li	st only one cause on ea	ach line.		,,,	-5.,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	neumon	ia			2 wks.
н	Examiner			Due to (i	or as a consequence of):	0-5 15	1 -		>V
		ē	S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a consequence of):	Carolismys	party		4 lars
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	0.		H. A E	1 1		1.000
<u>,</u>	sician and burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (d	or as sequence of):	1100000	tuur,		- DWKS.
8760,	ate be executed hysician and the burial-transit			4					
89	ficate phys	Physician/Medical		d					
Вох	The law requires that the death certifica tie has been signed by the attending pr tage 2 should be detached for use as it	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregnancy			23d. Date of deli	wen/
m	Jeath atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No			□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	that the de ed by the a detached	S	9 Unknown	9□ Unkno					
	res that igned b	by P	Part II. Other significant condi-	tions contributing to de	ath but not resulting in the i	inderlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds	quire n sig		Dem	entia			1 □ Y€	es 2∭XNo 3∏Pro	bably 4 Unknown
of Vital Records,	w requi	Completed	Coss	A	Nic Nic	2=	24a. Wasa	n 24h Wara aut	topsy findings available
Re	The lav	Ĕ	~~~	2000	mery Des	e45e	autops perforn	y prior to c ned? death?	ompletion of cause of
ā			25. Was case referred to medic	al V	V		1 ☐ Yes 2		2 No
Ξ	Physician: this certificantal director,	o Be	examiner?	Hospital:	ontine of FROM	Other	of Death (Check only on		
of	Phy raid	2	27. Manner of Death	28a. Date o	patient 2 ER/Outpatie	nt 3 DOA 4 Nur		ence 6 Other (Spec	ufy)
on	ding Phy	tlor	1 Natural 5 ☐ Pend 2 ☐ Accident inves		n, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ N		mary occurred	
isi	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could	not be on Di	of Injury - At home, farm, st			reet and Number or Rui	ral Route Number
Division	after Dira	Certification:	4 Homicide deter	mined 286. Place of buildin	g, etc. (Specify)	,,, 01100	City or Town	, State)	/ TOUTO : YUMDU/,
	To the Hospital or Attanwithin 24 hours after deatl To the Funeral Diractor:		29a. Certifier 15 Certify	ing Physician: To the I	best of my knowledge, deal	h occurred at the time, date and	place, and due to the co	Buse(s) and manner as	stated
	e Ho Fu letely	Medical	(Check only 2 Medica one)	I Examiner: On the ba	sis of examination and/or in	vestigation, in my opinion, death	n occurred at the time, da	ate and place, and due	to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certific	er		29c. License number	2	9d. Date signed (Month	, Day, Year)
			> Rehall-			D26242		5/1/06	
1	11		30. Name and address of person	n who completed cause	of death (Item 22a) /Ti-sa	Print)		3 111-0	
4	101		SHILBI KHUS	1	HAYS ST #	102, BEL A1	R, MB;	21014	
2	Sta	te	31. Date filed (Month, Day, Year		gistrar's Signature	1			
	Registr		MAY 0 3 20	06 Mesera	Jes Marie				

			For State Registrar	State of M	Marylan			t of He		d Mental F	lygien Reg. No	2006	13956
	/sicia		Decedent's Name (First, Middle, James	Last)	E.		Tuns	tall		2. Date of Month	Death Da 20	y Year 2000	
	amine	er	4a. Facility Name (If not institution, Union Memoria	l Home				Balt	ocation of De		40	. County of Dea	ath
Fune Direc			5. Social Security Number 218-22-8784 Usual Residence of Decedent	5. Sex 1 🛣 M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under 24 H Hours M	in. (Month,	Birth <i>Day, Year,</i> -15-28) 0	rthplace (State or Foreign country) Md .
Maryland Show	1000		10a. State 10b. County	NA	10c. Cit	y, Town or Lo Bal	cation Ltimo:	re					10d. Inside City Limits ↑▼ Yes 2 □ No
ith with the 23a or 28	DU BO 18m	al Director	10e. Street and Number 2567 Cecil Ave	nue			10f. Zip	Code 212	18		10g. Ci	tizen of What C	country?
ary/and 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show	Examinaria	by Fur	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force d 1 Tyes XI If Yes, Give Year or Date:	s? ⊒ No		Was Deced If Yes, spe- 1 Yes	cify Cuban	panic Origin? , Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 s marked other than "natural; or	IDE MESICAL	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th grade		or 5+)	life.	kind of wo DO NOT u	rk done du	ring most of v	working		at Offic	•
:	natic event,	To Be C	17. Father's Name (First, Middle, L Burrell	ast)	Tuns	stall			18. Mother's N Ange			Le	
9, Mar and 2 sh fealth and m 27 is m	ner traun	1	19a. Informant's Name/Relationsh Evertia Tunsta		Wife	25	76 Ce	ecil A		, Baltin	ore,	Md. 2	L218
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked	lury or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	ecify)	te C		natory or o	est Ve	et.¦Cer	Date n.5-4-06	5 0		Mills, Md.
Department Department	Suc suc suc suc suc suc suc suc suc suc s		21. Signature of Funeral Service L			М	larch	F.H.	East	1101	E. No	e, Md. orth Ave	
Physic /Medi			23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. AS	i line.	on T	_	1e of dying,	1	liac or respirator	y arrest,		Approximate Interval Between Onset and Death Nour
8760, ate be executed whysician and many the beautiful report to the beautiful	ne portial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (r :	a a consequence as a consequence	i ence of):							Britos
BOX 6 ath certif	or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1	23c. If yes, outcon 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3□	Ectopic po					23d. Date of de Month	elivery Day Year
Cords, P.O. I wrequires that the de been signed by the a	9	۾	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying o	ause giver	in Part I.		id tobacco		to the cause of death?
Vital Reco	age z	Completed								1 ☐ Ye	utopsy erformed? s 2 No	death?	autopsy findings available completion of cause of
thys shis	Tuneral direct	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigations.	28a. Date of In (Month, I		ER/Outpatien 28b. Time of Injury		Other 28c. Injury a Work?	4 Nursing	Death (Check on g Home 5 R 28d. Descrit	esidence		ecify)
DIVISION C tal or Attending P is after death.	ed in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At he etc. (Specif	ome, farm, str	eet, factor	y, office			n (Street al Town, State		Rural Route Number,
he Hospl in 24 hou he Funar	completely filled	Medical	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the basis and manner	of examina	wladge, daatt	vestigation	at the time , in my opii	date and sla nion, death oc	the and dualto to courred at the tin	ne, date an) and manner a d place, and du	s stated. e to the cause(s)
To I To I	Cod	2	29b. Signature and title of certifier	1) (a	TTH)	M.D.		AT S		946		ite signed (Mon	•
HA	.\		30. Name and address of person w	ho completed cause o	f death (Item	n 23a) (Type,	Print) 1emo	rial	Ho	spital,	MD		, 2006
Reg	Stat gistra		31. Date filed (Month, Day, Year)	0.7	strar's Signa	iture							

		For State Registrar	State of Ma	-	epartme Certifica					giene Reg. No	UUO	13957
W. Disyona	ion	1. Decedent's Name (First, Middle, La	st)					2	Date of De Month	ath Da	y Year	3. Time of Death
Physici /Medio		Nancy Evelyn Toml	in					1	Apr.1	30	2006	10:10 P M
Examir		4a. Facility Name (If not institution, given	re street and number)			y, Town, o			·	4c.	. County of Death	1
		Sinci Hospital of	Beltmore	-		Hma						
Funeral			Sex 7. Ag 1 □ M 2X F	e (In yrs. last birt	Months	er 1 Year Days	If Unde Hours	r 24 Hrs. 8 Min.	. Date of Bir (Month, Da	th y, Year)	9. Birth Cou	place (State or Foreign
Director		216-42-9081	ILIM ZALIF	63	rs.			C	9-04-19	942	Virg	inia
2		Usual Residence of Decedent 10a, State 10b, County		100 City Tour	or Longtion							10d. Inside City Limits
nylar how	_			10c. City, Towr	Baltir	20110						1 X Yes 2 □ No
the Marylan r 28e-1 ehow	cto	MD NA			ратсп	ipre						
or 28) re	10e. Street and Number			10f. Z	ip Code				10g. Cit	izen of What Cou	ıntry?
death with the Maryland ma 23a or 28e-f ehow rmwat be notified at	<u></u>	4002 Belle Avenue				2121	.5				USA	
	Completed by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec If Yes, sp	edent of H	lispanic O	rigin? (Speci	fy Yes or No	0-	14. Race - Amer Black, White	
w	F	1 Never Married 2 Married	1 Tes 2 X	No		2 X) No	Specify				Specify:	, 515.
036 ours after	by	3 Widowed 4 □ Divorced	Year or Dates:		10103	21110	Specii)				B]	lack
21215-0036 d within 72 hours all giene. "naturel", or then "naturel", or the Medical Exercity.	ted	15. Decedent's E (Specify only highest gr		16a.	Decedent's Us (Give kind of w	ual Occup	ation	st of working	,	16b. K	ind of Business/l	ndustry
within 7	ple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NOT	use retired	d)	- · · · · · · · · · · · · · · · · · · ·				
d with	0	12			Diet	ician				Sc	hools	
Maryland 2 nd 2 should be filed ith and Mental Hygis 27 is marked other traumatic event.	Be (17. Father's Name (First, Middle, Las.	7)				18. Moth	ner's Name (First, Middle	, Maiden	Sumame)	
lat be with the state of the st	70	Charles D. Braxton S	r.				Al:	lie M. F	Brown			
laryland 2 2 should be filed and Mental Hygis is marked other aumatic event.		19a. Informant's Name/Relationship	(Type, Print)	19b	Mailing Addre	ss (Street	and Numl	er or Rural F	Route Numb	er, City	or Town, State, Z	ip Code)
≥ 5€2;		Sherman Tomlin/Son		36	02 Cedar	dale R	load Ba	altimore	e, MD 2	1215		
re, Maryland stands and 2 should be filed the stand Sould be filed to 37 is marked other traumatic event,		20a. Method of Disposition		20b. Place of	Disposition (Ny, crematory or	ame of	cal	Dat	te	20c. L	ocation - City or	Town, State
Baltimore, bermit Pages 1 ar Department of Hea importent: If Item any in ury or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1	orial Pa			05-06-06	5	Rand	allstown,	MD
T L L L L L L L L L L L L L L L L L L L		21. Signature of Funeral Service Lice	**	King rien	22. Name					TUTTO	urro comity	
Baltimor permit Pages Department of I Importent: If Ite eny in ury or of		1. Signature of Fundamental Convictor Elect	Comp						Gi Imor	r Str	eet Nalto.	ND 21217
		23a. Part 1. Enter the disease, or con	anlications that causes	d the death. Do								Approximate
		shock, or heart failure. List only	one cause on each li	ne.								Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	-a. Ach	e Ische	nic Co	ichon	risel.	r Acc	c.dut	-		50.5
/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):							
Examine		Sequentially list conditions.	b									
g =	nei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):							
8 / bU, cate be executed obysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
e exe		resulting in death, cast	Due to (or as	a consequence	or):							
cate be exphysiclen the buria	dlcal	•	d					-				
	Mec	IF FEMALE:									1	
BOX of eath certifications as as	an/	23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth	of pregnancy 2 Petal death	3 Ectopic	pregnancy	у				23d. Date of deli	very Day Year
dea deat	Sic	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐Pregnant al	I time of death	5 Other (specify) _					77101111	July Cu.
by the a	Physiclan/Me	9 Unknown										
VISION OT VITAL MECOLDS, P.O. BOX of Attending Physicien: The law requires that the death certific death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death b	out not resulting in	the underlying	cause giv	en in Parl	: I.				the cause of death?
v require		Hypothesian							1 🗆	Yes 2	□No 3□Pr	obably 4XiUnknow
s bec	Completed								24a. Was		24b. Were au	topsy findings available
He la	Ē			_						ormed?	death?	topsy findings available completion of cause of
VITAI HEC sicien: The law certificate has b rrector, page 2 s	ပိ	25. Was case referred to medical	T				OC Die	a of Doosh	1 Yes	2 X No	1 ☐ Yes	2 No
VII Niciel Gerti	100	examiner?	Hospital:			Ott	_	ce of Death (5 (T) Oth (O	
Phys this aldid	To	1 Yes 2 No	Hospital: 1 Inpatie		tpatient 3				d. Describe		6 Other (Spec	ary)
ding h. After funer	0	1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year)	njury M	28c. Inju	rk? Yes 2[,		, , , , , , , , , , , , , , , , , , , ,	
Division of Vital Records, P.O. I or Attending Physicien: The law requires that the dather death. Director: After this certificate has been signed by the Jin by the funeral director, page 2 should be detached	cat	2 Accident investigation 3 Suicide 6 Could not	he				1103 2	28	of Longting	(Ctrant o	and Mumber or Pu	ral Route Number,
or At fter o	Certification;	4 Homicide determine	A 256. Place of inj	jury - At home, fa tc. <i>(Specify)</i>	irm, street, fact	огу, опісе		20	City or To	wn, Stat	e)	rai nodie radilber,
Divisit To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the												
dosp t hou une	Medical	(Check only 2 Medical Exa	hysician: To the best iminer: On the basis o	of examination an	a, death occurre d/or investigati	ed at the till on, in my o	me, date a opinion, de	and place, an eath occurred	nd due to the d at the time,	cause(s , date an	 and manner as d place, and due 	stated. to the cause(s)
To the I within 24 To the Complete	ed	one)	and manner st	tated.		20 - Lineau				1)0-1 D	to singed (Mage)	h Oay Vasal
T with Co	2	29b. Signature and title of certifier			4	29c. Licens				290. Da	ate signed (Monti	i, Day, rear)
		LAM	DO 20			KE	5-0	00		Apr	130,20	2006
1		30. Name and address of person who										
1/		Jenn. For Wheaton	, Do Sine:	rar's Signature	+ B. Itm	かし						
St	tate	31. Date filed (Month, Day, Year)	32. Regisli	rar's Signature	lank .							
Regist		MAY 0 3 200	Ref	ANT.	4-749 C 1 5 C							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** UON Nor Dec Marie 1,2006 /Medical 4a. Facility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death E RIVER VIEW BALTIMORE SSCX HOME NUTSING If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Oay, **Funeral** 1 □ M 2 🕽 F Months Days Hours Min. 213-60-403 Yrs. Director AUG Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits, 1 Yes 2 No balt Directo more sille 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8903 USA LANG Der 21234 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: Specity: WHite 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event. the Mer Elementary/Secondary (0-12) College (1-4or 5+) Home 10 th touse Wille NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VON Nordeck Serveca narles 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 06 LOTTPINE PK Com 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FUHERAL Paul Stella FUHERAL 7527 DAY Ford RU poce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Atherosclentic Immediate Cause (Final disease or condition resulting in death) Cardio vascular Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Demannic 3 Probably 4 ⊋Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes 25 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: ို 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1/Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ₹☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pcint) Back Rive Neck Road MALMOUD 201-109 31. Date filed (Month Day, Year) egistrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5/30 PM George Robert Washington 26 2006 4pri /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days Hours Min. (Month, Day, NA Hospital Union Memorial Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 78 Yrs. 218-24-2843 07-07-1927 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County in then "natural", or items 23s or 28s-f show the Medical Exeminal must be nutified at 1 ☐ Yes 2 No Baltimore Baltimore MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 50a McMechen 21217 deeth Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) London Supervisor NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic event gone. Deborah Washinston Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 502 McMechen St. Baltmore, MD 21217 Doris Virginia Washington 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) MD National Cemeter 5-3-00 Laurel, MD 22. Name and Address of Facility Eunetal Service 21. Signature of Funeral Service Licensee 5151 Boths Natt Pike Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days **Physician** Cere provascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No this certificate hes been si al director, page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 17 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 110061180 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East U 32. Registrar's Signature Baltimore, Mary land Partinay Elliot Share D.O. University 31. Date filed (Month, Day, Year) MAY 0 3 2006 Assale! State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** APRIL Vear RIS WILLIAMS 30 2006 MAGG: H /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Locetion of Death Examiner 4c. County of Death Glen Nursing Home NA BALTIMORE 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗵 F 214-24-00 80 Usual Residence of Decedent 81 Yrs. Director 08-07-1924 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or items 23a or 28a-f show any injury or other traumatic event, in Medical Examinal must be neitified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director BAITIMORE MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 329 ALLENIDALE STREET 21229 USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by 3 NSWidowed 4 ☐ Divorced Specify: BLACK 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 814 GRADE HOUSE KEEPER PRIVATE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES MATTHEWS ELLA PARRON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1884 CORNERSTONE WAY JOANN HEBRON BORDEN BAUD. MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 05.05.06 OWINGS MIUS, MD 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physiclan/Medical Examiner ettending physician end for use as the bunel-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) signed by the et d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ been si 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy his certificate hes b il director, page 2 s 1 Tes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendir within 24 hours efter death. To the Funerel Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) 29b. Signature end title Certifier 29c. License number 29d. Date signed (Month, Day, Year) arkare 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3451

\$2. Registrar's Signature

State Registrar

31. Date filed (Mo

			1 - For Stata Ragistrar	State of Maryland / D		artment of rtificate of				giene	13961
	Physici		1. Decedent's Name (First, Middle, Last)	WYCHE	6				2. Date of Dea Month	Day Y	3. Time of Death Year 340 PM
Н	/Medio Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,	or Location of	of Death		4c. County of	
			BON SECOUR HOSPI			BALTIMO				N	IA
	Funeral Director		5. Social Security Number Color	M 00 -	hday) (rs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birt (Month, Day 07. 03.	v. Year)	B. Birthplace (State or Foreign Country) MD
	yland		10a. State 10b. County	10c. City, Town	or Lo	ocation					10d. Inside City Limits
	e Mar	ctor	MD NA	BALTIMO	RE						1 MZYes 2 □ No
	with th	Director	10e. Street and Number	_		10f. Zip Code				10g. Citizen of Wh	at Country?
	eath v	erai	804 WALNUT AVEN	IUE 12. Was Decedent Ever in U.S.	12	212		-i-0 (C		USA	American Indian,
(O	r iten	Funerai	1 Married 2 Married	Armed Forces? 1 Ma Yes 2 □ No		Was Decedent of If Yes, specify Cul		n, Puerto	Rican, etc.)		White, etc.
8	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:			Specify: {	BLACK
15-(within 72 hours after death with the Maryland ene. than *natural', or Items 23a or 28a-f show he Madleal Exertinar mast be notified at	lete	15. Decedent's Educ (Specify only highest grade	cation 16a. [Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	t of worki	ng	16b. Kind of Busin	
212	within liene r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		URIER	9U)			DELIVERY	SERVICE
멀	al Hyg I othe	BeC	17. Father's Name (First, Middle, Last)				1		(First, Middle,	Maiden Surname)	
yla	ould b Ment Markec	To	WILLIAM WYCHE				FRAN	CES	WOODS	}	
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and once.		19a. Informant's Name/Relationship (Type FRANCES WYCHE	1						r, City or Town, Sta	ate, Zip Code)
Baltimore, Maryland 21215-0036	s 1 an f Heal item 2 other		20a. Method of Disposition	20b. Place of I		NALNUT esition (Name of matory or other pla			D. MD.	21229 20c. Location - Cit	ty or Town, State
Ę	Pages nent of I int: If its iry or o		1 Burial 2 Cremation 3 Re 1 Onation 5 Other (Specify)	emoval from State GARCISO				5.08	0,		MILLS, MD
ä	permit. Departm Importa any inju		21. Signature of Funeral Service License		22	Name and Addr	ess of Facility	v			VIIII VIII
	# Q E # 9	. ()	Dangha ()		51	SI BAUTO. N	JATC PLA	VE, B1	AUTO. MID	21229	
	Physician /Medical Examiner		23a. Part1. Equer the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	M(Certa	Pope Ros	2 C	2 y	est,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of							
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Bc. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 <u></u>]Ectopic pregnand] Other <i>(specify)</i> _	у			23d. Date o Month	
rds, P	w requires that been signed I should be det	ğ	Part II. Other significant conditions conf	tributing to death but not resulting in t	the ur	nderlying cause gr	ven in Part I.				ite to the cause of death? Probably 4 Onknown
Vital Records,	The law re ate has bee bage 2 sho	Completed							24a. Was a autops perform	prio dea	re autopsy findings available r to completion of cause of th? Yes \$ No
/ita	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?				26. Place	of Death	(Check only on		
Division of \	ding Ph n. After th funeral	ation: To	1 Yes 1 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir Inju		28c. Inju Wo	4-4-1	2		ence 6 Other ((Specify)
DIVIS	tal or Attendi rs after death. al Director: A ed in by the fo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, str	eet, factory, office		2	8f. Location (St City or Town	treet and Number on, State)	or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my knowledge, er: On the basis of examination and/ and manner stated.	death or inv	occurred at the ti restigation, in my	me, date and opinion, death	d place, a h occurre	nd due to the cand at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To t To ti comp	ž	29b. Signature and title of certifier	2		29c. Licens				9d. Date signed (A	Month, Day, Year)
a			west)		241	70	2		7/36/00	5
<u></u>)		30. Name and address of person who con		ype,	Print) Gw S	- Ba	Oten	- MD	2/20/	44
	Sta Registra		31. Date filed (Month, Day, Yeer) MAY 0 3 200	32/Registrar's Signature		wie					

30. Name and address of person (who completed cause of death (Item 23a) (Type, Print)

2006

HODICINS

32 Registrar's Signature

OTTO

MAY 0 3

31. Date filed (Month, Day, Year)

3. Time of Death

11:10A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

NOT KHOW

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

XXYes 2 No

MARYLAND

Black, White, etc.

Specify: BLACK

N/A

Registrar DHMH 17 Rev 1/2001

State

tospite

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Robert Wissinger 10:30 а м April 27, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard 4010 Hunt Avenue Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 175-20-4594 79 Director June 8, 1926 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturet", or items 23a or 28a-f sho: treumatic event, the Nacional Examinat must be notified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21043 4010 Hunt Avenue Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MNo Specify: þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) medical equipment Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If item 27 is marked other than quality control supervisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eliza A. Roberts 2 John L. Wissinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4010 Hunt Avenue Ellicott City, Maryland 21043 Ms. Erma Wissinger Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 Department of Important: If any injury or once. 05/01/2006 Johnstown, PA Forest Lawn Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. Mindfelle MUOSZE 3871 Old Columbia Pike Ellicott City, MD 21043 23a: Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Infimediate Cause (Final disease or condition resulting in death) **Physician** Abdominal weeks Lymphoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, indicause. Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by Rinal Failore Acote 3 Probably 4 Unknown Myelodys plasia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page Emphy 1 ema. certificate 2□ No 1 ☐ Yes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the for 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D Completely filled it 11x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D30573 4-28-06 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a d Minford, Jon MD 11055 Little Patuxent Pkwy. Columbia, MD 21044 32 Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 3 State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene (1) (1)

_			1 - For State Registrar	State of Mary		rtificate of l			Reg. No.	6 13964
	Physici	an	Decedent's Name (First, Middle, Last, Dicie	E.	Wood			2. Date of Dea Month	Day	3. Time of Death
2	/Medio		4a. Facility Name (If not institution, give		71004	4b. City, Town, or	r Location of Death	May 1,	4c. County of	11:00 P M
	Lxamii		Genesis Eldercare	- Heritage (Center	Dundal			Baltim	ore
	Funeral Director		5. Social Security Number 6. Sec 1233–40–5460		yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day August		Birthplace (State or Foreign Country) Test Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f aho	tor	Maryland Baltimor	е	D unda	1k				1 ☐ Yes 2X No
	or 28	Jirec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath w	rail	7230 Sollers Point			2122			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Itams 23a or 28a-f ahow any injury or othar traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1□Yes 2√2 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black,	American Indian, White, etc. White
5-0	72 hg	etec	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occupa	ation during most of worki	ng	16b. Kind of Busi	ness/Industry
12	within ane. then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)					O	1
р 5	Hygie Hygie other		12 years 17. Father's Name (First, Middle, Last)		Se	lf Employ	'ea 18. Mother's Name	(First, Middle,	Cosmeto Maiden Sumame	
Maryland	id be fental rked c	To Be	Huey Green				Rebecca	Pendry	7	
ary	shou and N s mar	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	I Route Numbe	r, City or Town, St	ate, Zip Code)
	and 2 ealth m 27 i		Tom Wood	Husband			Point Roa			
Baltimore,	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)			sition (Name of matory or other place Cemetery	MAy 4	, 2006	20c. Location - C Dundalk,	
l Ball	permit Depart import any in		21. Signature of Funeral Service Licens	onnell	4 3	Name and Address onnelly F 110 Solle	uneral Hoers Point	me Of D Road, D	oundalk,Poundalk,M	Ď. 21222
			23a. Part1. Enter the disease or compleshock, or heart failure. Vist only or				g, such as cardiac c	or respiratory arr	rest,	Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition resulting in death)	DIVERT	TI Cles	515				Onset and Death
	/Medical Examiner		1 SSSMING III SSSMIN)	Due to (or as a con Due to (or as a con Due to (or as a con Due to (or as a con	sequence of):	- 60.	150	5.41	ILRE	2
	No. of the same of	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):	1 5-01	TONE	DIAL	DAN	
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	END ST	TAGE	DEM	ENTIA	h	JULY !	
oʻ	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a con	sequence of):	TECTO		-		
68760,	ate be	edicai		K16147	MAS	rec 10	MX			
9 ×	ding p		IF FEMALE:	3c. If yes, outcome of pre	agnanov					
.O. Box	The law requires that the death certaine has been signed by the attendin bage 2 should be delached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Month	,
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	stributing to death but not	resulting in the ur	nderlying cause give	en in Part I.			ute to the cause of death?
Records,	The law re ate has bee bage 2 sho	Completed						24a. Was a autops perform	med? prid	ore autopsy findings available or to completion of cause of ath?
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death			
	Physician: r this certific ral director,	၉	1 □ Yes 2 □ 160		2 ER/Outpatien		4 ursing Hor		ence 6 □Other	
Division of	ding After	Certification:	27. Manner of Death 1 CNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea			vat k? Yes 2 □ No	28d. Describe h	ow injury occurred	
N N	200		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecity)		-	City or Tow	n, State)	or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	one) 2 Medical Exemil	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	estigation, in my op	pinion, death occurre	ed at the time, d	late and place, and	d due to the cause(s)
)	o T will	~	29b. Signature and title of certifier	1 (rio)	Ans	29c. License	7 7 / RO	2	19d. Date signed (Month, Day, Year)
	- X		-UNIMARI	1 1 WIL			100		0/4	01-
1	1		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type. I	Print) . (7)	_			
-	l		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, I	Print) PK	us Du	wsni	R MI	0 2/222

Richard Charles Wolfe

Please Type or Print in Black Indelible Ink

State of Maryland	Department of Health	and Mental Hygiene

	1- For State Registrar	Certific	Re	eg. No. 2006	13965	
Physician/ Medical Examine	Decedent's Name (First, Middle,La	Charles	Wolfe	2. Date of Deat Month April 27, 2	Day Vear	Time of Death 1608 hrs
	4a Facility Name (if not institution, g 2100 Huntingdon Avenue		4b. City, Town, or Location of Baltimore	Death	4c. County of Death NA	
Funeral Director	196-32-2263	Sex 7. Age (In yrs. last b) 7.	rthday) If Under 1 Year If Under Months Days Hours Yrs.	24Hrs 8 Date of Bird Min. 10-6-	th (MM/DD/YYYY) 9. Birth; Foreign Coun	olace (State or trDelaware
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow			1	0d Inside City Limits
* .	Md.	NA F	Baltimore		Og. Citizen of What Countr	Yes 2 No
uth the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 4627 Kenwick Ro	pad	10f. Zip Code 21210		USA	y r
	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No ad If Yes, Give Year	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 X No specify:		- 14. Race - America White, etc. Specify: Whit	
ours after a standard samine	15.0	only highest grade completed) 16a	Decedent's Usual Occupation (Give k during most of working life. DO NOT		16b. Kind of Business/Inc	
5-0036 ed within 72 hours tygiene other than "natu the Medical Exan	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+) M . A .	Cab Driver	,	Yellow Tra	nsporation
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be To Be Completed by Funera		st)		s Name (First, Middle, N		
MD 21; 12 should b 12 should b 127 is mar 107 Is mar		Brother	9b. Mailing Address (Street and Num 65 Bayberry Lane	, Loudonbe	rry, New Ham	pshire
nore, lages I and ages I and of Healint: If item	20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Speci	Removal from State Green	e of Disposition (Name of cemetery, atory or other place) nmount Cem.	Date 5-2-06	20c. Location - City or To Baltimore,	_
Baltir permit. F Departme Importa injury or	21. Signature of Funeral Service Lic		22. Name and Address of Fadility March F.H. Eas		altimore, Mo E. North Ave	. 21202
Physician /Medical	failure. List only one cause on	implications that caused the death. Do each line.	not enter the mode of dying, such as ca	ardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Atherosclero Due to (or as a consequence of):	tic Cardiovascular Disease			
rei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):				
uted and ransit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): d.			· ·	
f760, ficate be executed ficate be executed by physician and the burial - transit	UNPENDED	AMENDED				
the death certificate be the death certificate by the attending physic ched for use as the burn burneric and Mondal	23b Was decedent pregnant in the	23c. If yes, outcome of pregnand 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic 5 Other (Specify)	pregnancy	23d. Date of delivery Month Da	y Year
_ e _ f e _ 5	5	s contributing to death but not result	ing in the underlying cause given in Pa		obacco use contribute to the	
Division of Vital Records, P.O. Box 68 within 24 hours after death certificate has found and attending Physician. The law requires that the death within 24 hours after death completely filled in by the funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as completely filled in by the funeral director, page 2 should be detached for use as				24a. Was autop perfo	prior to co rmed? death?	opsy findings available mpletion of cause of
tal R cian: T certifice ector, p		Hospital:	26 Place of Death	·		
of Vit g Physic fter this neral dir	1 Yes 2 No	28a. Date of Injury 28	Outpatient 3 DOA Other 4 DOA Chief 4 DOA DOARD THE PROPERTY OF	Nursing Home 5 28d. Describe	Residence 6 Other:	Scene
Sion (Attendin death ctor: A: y the fur	1 V Natural 5 Pending 2 Accident Investig	ation	1 Yes 2 farm, street, factory, office building, et		Street and Number or Rura	al Poute Number City
Division o spital or Attending nours affer death meral Directors: Afte filled in by the fune	3 Suicide 6 Could r 4 Homicide determ	ned (Specify)		or Town, S	State)	
To the Hospital within 24 hours a To the Funeral I completely filled		sician: To the best of my knowledge, oner: On the basis of examination and/of and manner stated	death occurred at the time, date and plate investigation, in my opinion, death oc	ace, and due to the cause curred at the time, date	and place, and due to the	cause(s)
	29b. Signature and title of certifier	enica - Poll	29c. License number O.C.M.E.		29d. Date signed (Mont April 28, 2006	th, Day,Year)
1	30. Name and address of person w Patricia Aronica-Pollak	ho completed cause of death (Item 23a		altimore, MD 2120)1	
Star Registra		32 Registrar's Signature	Sporte			
	WHY U 3 C	elle and a second				

			1 - For State Registrar	State of Ma	aryland /	Depar		of H	ealth a		ental Hy		06	13966
	Physici /Medio	al	Decedent's Name (First, Middle, L. A A Facility Name (If not institution, gi	White			Ib City Tou		Location		2. Date of Dea	25	2 Job ounty of Death	3. Time of Death
	Examin Funeral Director	er	Genesis Homeu 5. Social Security Number 6.	Sex 7. Age	o (In yrs. last bi	irthday)	If Under 1 Y	Sto	If Under:	_	8. Date of Birt (Month, Day 8–9-		NA 9. Birthy	olace (State or Foreign
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov									Od. Inside City Limits
	th the Mar or 28a-f s e notified	lrector	Md. NA			Balt	imore	ode 212	12			10g. Citizei USA	n of What Cou	1 X Yes 2 □ No ntry?
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or liems 23a or 28a-f show is Madical Eriar ii ar reast ke Indiffical at	oy Funeral [1300 E. Lanvale 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent I Armed Forces? 1 □ Yes 2 ▼ If Yes, Give Year or Dates:				t of His Cubar		gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	14.	. Race - Ameri Black, White,	etc.
	I within 72 hour iene. r than "natural is Medical E	To Be Completed by Funeral Director	(Specify only highest g. Elementary/Secondary (0-12) 6th grade	ducation		(Give kir life. DC	nt's Usual O nd of work d NOT use r memak	lone d etired)	ition uring most	of workin	g		of Business/In	^{dustry} ildern's As
Maryland ?	uld be filed Aental Hygie rked other tic event, II		17. Father's Name (First, Middle, Las June	t)	Lynch	h				rs Name Vetti	(First, Middle, e	Maiden Su	_{umame)} Ly	nch
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or flems 23a or 28a-f show appring yor other traumetic event, It a Medical Event in attract the rediffical at once.		19a. Informant's Name/Relationship Marion Turner 20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 3 4 □ Donation 5 □ Other (Spec	Granddaug	hter	2607 of Disposit ery, crema	Aisq	uit of r place	h St.	, Ba	ltimore	e, Md.	own, State, Zip. 2121 tion - City or To	own, State
Baltin	permit. F Departme Importer eny injur		21. Signature of Furieral Service Lice		DEU	22. N	Name and A arch l	ddres		у	Balti	more	, Md. cth Ave	21202
760,	that the death certificate be executed EX Medical By the attending physician and detached for use as the burial-transit	lical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	s (Z) a consequence	of):	Ither							Approximate Interval Between Onset and Death
.O. Box 68	the death certifica y the attending ph ched for use as ti	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deatl		ctopic pregr Other (specif					230	d. Date of delive Month	ery Day Year
Ω_	iw requires that the s been signed by th ? should be detache	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							te. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probabiy 4 □ Unknown				
on of Vital Rec	The law ite has b	Completed									1 Yes	rmed? 2 No	24b. Were auto prior to co death? 1 Yes	opsy findings available mpletion of cause of
	ling Phys t. After this funeral di	To B	O 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 F F 27. Manner of Death 1 November 1 November 1 November 1 November 1 November 2 Nov						28c. Injury at Work? Mursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Work? M 1 Yes 2 No					
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	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ledical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination a ted.	nd/or inve	stigation, in	ту ор	inion, dea	th occurre	d at the time,	date and pl	ace, and due t	o the cause(s)
	with To	Σ	29b. Signature and title of certifier				29c. Li	icense	number	23	,	290. Date s	signed (Month,	Day, Year)
• ;	Sta Registi		30. Name and address of person who was a subject of person who was a subject of the subject of t	completed cause of d	eath (tem 23a)	(Type, Pr	int) BIV	2	POB	H30_	3 Bu G	trongs	MA	2/239

-	Examin Funeral Director
and 21215-0036	the filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or freme 23s or 28s-f show cevent, the Medical Exercitivers and the indiffied at

that the death certificate be executed Division of Vital Records, P.O. Box 68760 After t death. after death ō

2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 29, 200 gar LESTER LEE 10:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death MIDDLE RIVER

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Month, Day, Year)

NOV. 14, 1949 BALTIMORE APT. 601 SOPWITH DRIVE 6. Sex 14 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. 8 irthplace (State or Foreign Yrs. 214-50-3936 56 MARYLAND Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Funeral Director BALTIMORE MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT. 601 SOPWITH DRIVE 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, White, etc. 1X Never Married 2 Married 1 Yes 2 No δ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) Colfege (1-4or 5+) N/A DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should b Department of Health and Menti-Important: if Item 27 Is marked any Injury or other traumatic e ance. WATTS CLESTON AUDREY McCAULEY Baltimore, Maryla 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 S. DEAN STREET, BALTIMORE, MD. AUDREY WATTS/ MOTHER 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuriaf 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMETERY 5/4/06 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. Approximate Interval 8etween Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit 1110015 Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of defivery 3 Ectopic pregnancy ate has been signed by the ette page 2 should be detached for Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours after To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05/02/2006 D 24303 -d Nes 2227 HIGHLANDTOWN COMMUNITY 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) HEALTH CENTER 3509 EASTERN AVENUE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State BALTIMORE, MARYLAND 21224 Registrar

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Ma	-	epartment of H Certificate of L			efic 06	13968
Phys		n	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month And Decedent's Name (First, Middle, Last)						Day 12 Year	3. Time of Death
	edica mine	r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of							10 0 1
Funer Direct			5. Social Security Number 6. S 219 12 8960		e (In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 14	Year) 9. Bird , 1925 Mar	thplace (State or Foreign buntry) yland
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with the		5	10e. Street and Number 400 Gillespie	Street		10f. Zip Code 212	225	10	g. Citizen of What Co U.S.	ountry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural; or Itama 23a or 28a-f show any Injury or other traumatic event, the Madical Examination and		by Fur	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ∑Yes 2 ☐ I If Yes, Give Year or Dates:		13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 21 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
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Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. i71s marked other than "natural", or traumatic event, Its Medical Exam		å n	17. Father's Name (First, Middle, Last) itz Zukaiti	c		18. Mother's Name	e (First, Middle, M	aiden Sumame)	
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i, Ma and 2 s saith ar n 27 is		-	Dorothy Zukaitis	s / wife		Gillespie	4		re, Maryla	
altimore, rmit. Pages 1 ar partment of Hea portant: if Item y Injury or other			20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Contro		cemetery	Disposition (Name of crematory or other placen Cemetery	5/3/2	2006 E	oc.Location · City or Saltimore,	Maryland
Balt permit. Depart Import	Suc		21. Signature of Funeral Service Lice	msee Enamu	ouchs	22. Name and Addres				ce, P.A. yland 21225
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1			30. Name and address of person who	completed cause of d	eath (Item 23a) (7	ype, Print) HVSpi +	2) Av.	, baler	Bur	n't, mp
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday	If Under	01111	If Under	-	8. Date of Birt	h	9. Birth	place (State or Foreign
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	/lanc		10a. State 10b. County		10c. Ci	ity, Town or L	ocation							10d. Inside City Limits
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٦of			27. Manner of Death		e of Injury onth, Day Year)	28b. Time o	of 2	28c. Injury Work	at ?	2	28d. Describe h	ow injury oc	curred	
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Division	or Attended efter death Director:	iffe	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	ce of Injury - At h	nome, farm, st	reet, factory	, office		2			imber or Rui	ral Route Number,
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	n 24 n 24 se Fi	edical	(Check only 2 Medical E	xaminer: On the and ma	basis of examin- inner stated.	ation and/or in	nvestigation	, in my op	inion, dea	th occurre	ed at the time,	date and pla	e, and due	to the cause(s)
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	1 1 1,		30. Name and address of person	who completed cal	use of death (Ite	m 23a) (Tvpa	Print)					11/21/1	A.	Limovo
	•		JANESCHEL	- The	Johns He	pokins	Hosnit	W/ 1/21	10 No.	th We	Ife Stro.	et ma	110/130	1+imore 4, 21287
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician RENE ROWN MAI 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MORE Hrs. 8. Date SITCHIE HOSPICE Year If Under 24 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, FEB. 0 Birthplace (State or Foreign Country) **Funeral** 8-18-7990 1 □ M 2 🔀 F Days Min Yrs. Director MAR ANL Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rai', or iteme 23a or 28a-f ehov Examinar must be retified at Director 1 Yes 2 No MARYLAND 10e. Street and Number 10g/Citizen of What Country? 12 WOOD ST. by Funerai 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or item any injury or other traumatic event, the Mudical Exacts and 1 Never Married 2 Marned 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentary/Secondary (0-12) College (1-4or 5+) NUR Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be AMUEL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER-IN-LAW) 16/3 EUIHWI
20b. Place of Disposition (Name of cemetery, crematory or other place) YIVIAN EUTAW PLAC BAITO, 20a. Method of Disposition Date 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation METERY 05-09-0 4 □Donation 5 □ Other (Specify) e of Euneral Service Licensee 21. Signatu 22. Name and Address of Facility BROWN JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Coro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 5 Other (specify) 4 Pregnant at time of death detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one)

Vital

certificate death. hours after filled in

the Hospitei or Attending Physician: within 24 hours a To the Funerel C To the Fune completely fi

Medicai Certification; To

31. Date filed (Month, Day, Year) MAY 0 4 State Registrar

1 ☐ Yes 2 No

5 Pending

investigation

4

6 Could not be determined

27. Manner of Death

1 Naturat 2 ☐ Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signature and title of certifie 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) R. ANANDA

2006

P3HNAN 221 gistrar's Signature 32.

1 Inpatient

28a. Date of Injury (Month, Day Year)

N. E 7+W 57 \$305

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2 ER/Outpatient 3 DOA

28b Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death	
Month	3. Time of Death
	2006 Year 12:30 Mp
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
	Baltimore
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Day, Yes. Months Days Hours Min. (Month, Day, Yes.)	9. Birthplace (State or Foreign Country)
Usual Residence of Decedent	1922 Maryland
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Ohio Cuyahoga Cleveland 10e. Street and Number	1 ☐ Yes 🏖 No
10e. Street and Number 10f. Zip Code 10g.	. Citizen of What Country?
Ohio Cuyahoga Cleveland 10e. Street and Number 3330 Klusner Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA
Ohio Cuyahoga Cleveland 10e. Street and Number 3330 Klusner Ave. 12. Was Decedent Ever in U.S. Aggied Forces? 1 Never Married 2 Married 1 Married 2 Named Forces? 1 Never Married 2 Married 2 Named	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 1 Yes 2 No Specify: White 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes, Oral at 1 Yes 2 No Specify: White	Specify: white
1 Never Married 2 Married 1 Yes, Give Year or Dates: 1 Yes 2 No Specify: White 1 Yes 2 No Specify: 1 Yes 2 No Specif	b. Kind of Business/Industry
(Specify only highest grade completed) (Sive kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) (Sive kind of work done during most of working life. DO NOT use retired)	-
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) City Worker 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) City Worker 17. Father's Name (First, Middle, Last)	ty of Parma
T7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid	den Sumame)
1 Yes 2t No Specify: White Specify Specify Specify: White Specify Specify Specify: White Specify Specify: White Specify Specify: White Specify Specify: White Specify Specify: White Specify Specify: White Spe	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Ci Patricia A. Walocko - Daughter 129 Willow Bend Drive Owings M	
Care and the marcollo Datasirollo Mariatow Delici Di Life (Willing M	Location - City or Town, State
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Method of Disposition 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify)	
1 Burial 2 Mcremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 21. Signature of Funeral Service Licensee	1timore, Maryland
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Marylan 299 Frederick Rd. Baltimore	nd Inc. Maryland 21228
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each dig.	
	Onset and Death
Physician Medical Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Blackles CANCEA	Vic Go
Sequentially list conditions D.	year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0
g trial initiated events c. Due to for as a consequence of the	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery
Section of the second of the	Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc	co use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc of the part of	2 No 3 Probably 4 □Unknown
24a. Was an autopsy performed a saminary performed to medical examinary performed to the control of the control	
24a. Was an autopsy performed 1 □ Yes 2 ☑ 25. Was case referred to medical examiner? Hospital: □ Cher.	
1 ☐ Yes 2 ❷ 25. Was case referred to medical 26. Place of Death (Check only one)	No 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 27. Manner of Death 28. Date of Injury 28. Time of 1985 Injury	e 6 Other (Specify) 1050; CE
1 Inpatient 2 ER/Outpatient 3 DOA Working Home 5 Residence 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how in 1 Natural 5 Pending Natural 5 Pending Nat	
1- Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined to the property of the pro	
28d. Describe how in the property of the prope	t and Number or Rural Route Number, tate)
2 29a. Certifier Check only Check only 2 ☐ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause of the course of the course of the cause of the course o	o(s) and simple stand
Second Part Second Part	e(s) and manner as stated. and place, and due to the cause(s)
	Date signed (Month, Day, Year)
My buthen they und 025205 M	Ay 3, 2006
30. Name and address of derson, who completed cause of death (Item 23a) (Type, Print) 6601 N. CHARLES 572	RET .
Towson, MD 2120	34
State Registrar MAY 0 4 2006	

			1 - For State Registrar	State of	Marylan		artment rtificate			and Me		giene Rog. No	UUD	1397	2
	Physici	an	Decedent's Name (First, Middle,	·							2. Date of De. Month	Day	y Year	3. Time of De	ath
	/Medic	al	Marian Fr. 4a. Facility Name (If not institution,				45 00 0		1	15 11	MAY 2		06	8:16A	М
	Examin	er	CIVISTA MEDICA		iber)			PLA	Location o	t Death		4c.	CHARLE		
	Funeral				7. Age (In yrs.	last birthday)	If Under	1 Year	If Under a		8. Date of Birt	h		hplace (State or Fountry)	oreign
	Director		578 40 4334	1□M 2□F	76	Yrs.	Months	Days	Hours	Min.	Dec 3			untry) nington [
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town or Lo	cation							10d. Inside City L	
:	Mary -f sho	tor	Maryland Prince	Coorgo!s		D								1 Tes 2] No
	death with the Maryland ms 23a or 28a-f show	Directo	10e. Street and Number	ocorge s		D	randy 10f. Zip					10g. Cit	izen of What Co		(X
	23a o		13200 Brandy	wine Road				2061	5			Uni	ted Stat	es	
	tams	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spec	cify Yes or No lican, etc.)		14. Race - Ame Black, White	rican Indian,	
50	rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ ☐ Divorced	lf Yes If Yes, Give Year or Da	Z T No X X		1 ☐ Yes 2	. □ No	Specify:				Specify:		
9500-c	atura ical E		15. Decedent's	Education		16a. Deced	dent's Usua	Occupa	ation			16b. Ki	Mh ind of Business/	nite Industry	
7	within 72 hours after ene. She. Than "natural", or its than "natural", or its than "natural", or its than than the energy of t	Completed	(Specify only highest Elementary/Secondary (0·12)	Grade completed) College (1-	4or 5+)	(Give	kind of won DO NOT us	k done d e retired,	luring most)	of working	g			,	
N.	lygien her th		12			Sec:	retar	У					eral Gov	ernment	
and	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avant, the Mudical Exeminer must be notified at once.	Be c	17. Father's Name (First, Middle, L Paul G. Co						18. Mothe	_	(First, Middle, n Maric		Shelton		
	nd Me mark	ဥ	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	ng Address	(Street a	and Numbe				r Town, State, Z	ip Code)	
ž :	and 2 salth a n 27 is		Michael R. Bed	ck (Son)		13206	6 Bran	ad ww	ina P	hea	Brandy		e, MD 20		
eo .	of He of He fitam roth		20a. Method of Disposition XXBurial 2 Cremation	3 Demoval from S	20b. F	Place of Dispo	sition (Nam	e of her place	9) _M	Da	ite	20c. Lo	cation · City or	Town, State	
	Pages Iment of I tant: if its		4 Donation 5 Other (Sp.	ecify)	C	euar ni	LTT CE	emet	erv:				itland,		
Dall	Departs Departs mports any inj		21. Signature of Funeral S	densee	1146	4 22	. Name and	Addres	s of Facility	Lee	Funera	1 Hc	ome,Inc	6633 01d	
			23a Part1. Enter the disease, or o	complications that ca	used the deat						oad, C1		on, MD	20735 Approximate	
±. •	hysician		shock, or heart failure. List o Immediate Cause (Final	nly one cause on ea	ch line.	601	1	<i></i>	1100	1 . (O > > 5			Interval Betwee Onset and Dear	
	/Medical		disease or condition resulting in death)	a. Due to (c	r as a conseq	uence of):	MIK	ガジャ	- KAC	LX	10071	>,			
45	Examiner		Sequentially list conditions.	6. Ba	nal	Du	Jue	Ar	cu	~~	1				
,	asit and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du d to (d	r as a conseq	uence of):	1	1		(
	axecul n and al-trar	xan	that initiated events resulting in death) Last	c. Due to (c	r as a conseq	uence of):					7				
00/0	cate be executed physician and the burial-transit	dicai E		d											
0	ng ph		IF FEMALE:												
, מ	arn ce ttendi or use	iclan/Me	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	death 3	Ectopic pre					2	23d. Date of deli Month	very Day Year	,
5	inat the death certific ed by the attending p detached for use as	Physic	1 ☐ Yes 27 No 9 ☐ Unknown	4∐Pregna 9☐ Unknov	nt at time of d	eath 5□	Other (spe	cify)					WOTH	Day Tour	
Ĺ	ine aw requires that the death certificate has been signed by the attending prage 2 should be detached for use as	by Ph	Part II. Dther significant condition	s contributing to dea	ath but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of death	n?
cords,	w requires been sign should be										1 □ Y	'es 2[□No 3□Pro	bably 4 Dinkr	nown
ט ט	as been s 2 should	plet									24a. Was autop		24b. Were au	topsy findings avai	lable
	certificate has ector, page 2	Completed									perfor		death?	2 No	3 01
טו אוומו	Certific Sector	Be	25. Was case referred to medical examiner?	Hospital:				Otho			Check only o				
5	rthis ral dii	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of			4 🗆 Nur		e 5 🗆 Resid		Other (Spec	ufy)	
5	ath. r: Afte e fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month	, Day Year)	Injury	м	c. Injury Work 1 Y	? ′es 2 □ N			o i i i jui	y occurred		
2 3	er dear	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place	of Injury - At ho g, etc. (Specify	ome, farm, stre	et, factory,	office		28	Bf. Location (S City or Ton			ral Route Number,	
5	ral Di			- N					<u>-</u>						
-	to the most period of without and period of the awithin 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the b xaminer: On the bas and manne	sis of examina	wledge, death tion and/or inv	occurred a restigation, i	t the tim in my op	e, date and inion, deat	l place, an h occurred	nd due to the of d at the time, o	ause(s) date and	and manner as place, and due	stated. to the cause(s)	
4	withir To th comp	Me	29b. Signature and title of certifier	1/1			29c.	License	number			29d. Dat	e signed (Monti	Day, Year)	
	1		Agun	Well	~~	M		D-20	0629			5	13/0	6-	
	ý		30. Name and address of person w									2060	03		
	Sta		GEORGE H. WATHEN 31. Date filed (Month, Day, Year)		PEMBR(gistrar's Signa	OKE SC	UARE.	SUIT	re 10:	3 WAL	DORF,		LAND		
	Registr			2006	ven B	ture	de								

MARIAN F.

			1 - For State Registrar	State of Man		artmen rtificate			and Me	, ,	ene	6 i	397	13
*	Physici	an	1. Decedent's Name (First, Middle, Las						2.	Date of Death Month	Day	Year	3. Time of	
	/Medic		BERNICE	BOAR	POLEY				and the second	APR.		2016	133	3 U M
	Examin	er	4a. Facility Name (If not institution, given Anne Arundel Me		tor			Location o	f Death		4c. County		nde1	
3			5. Social Security Number 6. S		n yrs. last birthday		24	If Under 2	24 Hrs. a	. Date of Birth	Allile			or Foreign
Age to the second	Funeral Director			□ M 2 NB F	91 Yrs.	Months	Days	Hours	Min.	(Month, Day, 1)	1915	D.C	lace (State o	" Toloigii
	7		Usual Residence of Decedent						12	CD 17	1010			
	show	_	10a. State 10b. County		Oc. City, Town or L							1	0d. Inside C	
	8a-f 1	5	Maryland Prince	seorge's	Landov									2 X No
	vith th	Funeral Directo	10e. Street and Number			10f. Zip		705		10	g. Citizen of		itry?	
	s 23	erai	3107 Manson Pla	12. Was Decedent Eve	rin II S 13	Was Dagan)785	nin? (Specif	fy Ves or No.	US A	e - Americ	an Indian	
	ter d	Ę.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No	10.0.	If Yes, spec	ify Cuba	n, Mexican	, Puerto Ric	fy Yes or No- can, etc.)		ck, White,		
036	hours after death with the Maryland jurel', or Items 23s or 28s-f show at Exert. at must be notified at	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 Tes	2[XNo	Specify:			Specif	y Bla	ck	
5-0036	72 hours 'natursl', dicel Ex	Completed	15. Decedent's Ec	lucation de completed)	16a. Dece	edent's Usua e kind of wor	al Occupa	ation du <i>ring</i> most	t of working	1	6b. Kind of B	iusiness/In	dustry	
21	C . D	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	se retired)	· · · · · · · · · · · · · · · · · ·					
121	be filed withi stal Hygiene. od other then svent, the M		12th 17. Father's Name (First, Middle, Last)	00		Homer	nake		r'e Name /	First, Middle, M.	Nor			
anc	id be fi lental F ked of ic svsi	To Be	Frederick D. Ne							Scott		110/		
Maryland	s 1 and 2 should be filed within ! Health and Mental Hygiene. tem 27 is marked other than other traumatic svent, tha M	ř	19a. Informant's Name/Relationship (19b. Mail	ina Address	(Street a			Route Number,		. State. Zio	Code)	
Ma	nd 2 s lith ar 27 is r trau		Gloria Wallace	**		Mans				andove				
J.			20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Nan	ne of	ا (م	Date	e 2	0c. Location	- City or To	wn, State	
9	0 = 5		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification)		Bellvill				5-2-0)6	Suffo	1k, '	Va.	
Baltimore,	permit. Pag Depa tment Important: any injury o		21. Signature of Funeral Service Licer	see	3	2. Name an	d Addres	s of Facility	Sons	Mortua	erv.	DΔ		
<u>m</u>	88 5 8		Jarry 19,7	Seese MOOY						polis			0.1	
l.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not er	nter the mod	e of dyin	g, such as	cardiac or re	espiratory arres	st.		Approximat Interval Bet	tween
	Physician		Immediate Cause (Final disease or condition	a le	enal	far	lu	1	ć	car	2		Onset and	un.
8	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):	1	44.	•	0)			0	
	- LAUITIMICI	<u>_</u>	Sequentially list conditions,	b. Due to (or as a c	- 3 pur	, Ten	100					C	we	И
1/	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000 10 (0. 00 0	osocato., co o.i.).							(,	
,	executed n and ial-transit	Exai	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):									
160	ite be ex iysician ne buria	call	(d										
89	tifical ng phy as th													
Вох	death certifica e attending ph of for use as tl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2 (□Ectopic pr	egnancy					ate of delive	•	Year
_*	the at hed fo	sici	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at tim 9☐ Unknown	ne of death 5	Other (sp	ecify)				IVI	onth	Day	T Ball
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions of	eatsbuting to death but s	ent coculting is the	undorhing o	21122 2111	on in Dart I		23e. Did toba	2000 1100 000	teibuta to th	on named of	death?
S,	es pe	Completed by	Dilah Dilah	on dia h	2000 H	underlying C	ause givi	BILLIL FOLICI.			2 No			O nknown
O.C.		etec	19/2014) 0 1:0 10	1								
Records,	has has	mpi								24a. Was an autopsy perform	1	prior to co death?	psy findings mpletion of c	available cause of
a	T. Tale	-	25 Man ages referred to modical							1 Yes 2	No _	1 🗆 Yes	2□ No	`
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DO	Oth	ar		Check only one 5 ☐ Resider		has /Cassil		
ō		n: To	27. Manner of Death	28a. ate of Injury	28b. Time		28c. Injun Wor			d. Describe how			y)	
ion	Attending In death.	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	e <i>ar)</i> Injury	м		K? Yes 2⊡I	No					
Division of	Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury building, etc. (- At home, farm, s	treet, factory	y, office		281	f. Location (Stre City or Town,		ber or Rura	I Route Nun	nber,
Ō	rs afte al Dir	Cer			, , , ,									
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exat	ysician: To the best of r niner: On the basis of ex	amination and/or i	th occurred nvestigation	at the tin	ne, date an pinion, dea	d place, and th occurred	d due to the car at the time, da	use(s) and m te and place,	anner as s and due to	tated. the cause(s	s)
	the 2 the mplet	Med	one) 29b. Signature and title of-certifier	and manner state	1.	290	c. Licens	e number		29	d_Date signe	ed (Month.	Dav. Year)	
	with To Con		marchel	Detox.	Hym				435					To
7	,	7	30. Name and address of person who	completed cause of deat	h (Item 23a) (Type	. PrioNo		1 7 1	1 - 6	, /	100		,,,,,	
	0	-	MICHME J.1	a/ NTA	MY MY	8101	FE	USE	H16+	8 ×	NAA	2041	MO2	1401
李维	Sta	ite	31. Date filed (Month, Day, Year)	6 72 Registrar's	Signatur	- Car				, ,				
1	Regist	ar	III/II O Z Z	A. C.	W									

			For State		and / Depa	artment of H	ealth and N	-		nbie.	100	71
			State Registrar		Ce	rtificate of L	Death	2. Date of Deat	g. No.	U O	3. Time of	Dooth Dooth
***	Physicia	an	1. Decedent's Name (First, Middle, Last) Earl Brown					Month April	Day 26	2006	9:00	
	/Medic Examin		4a. Facility Name (If not institution, give street and			4b. City, Town, or			4c. Coun	ty of Death	_	
	i v.		Annapolis Nursing			Annapo	Olis If Under 24 Hrs.	Double of Disk	Anne	Arur		- Caraina
- 194 - 194 - 194	Funeral Director		5. Social Security Number 6. Sex 1219-32-3483 1X M 2		yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar 2	1934	Mary	lace (State of try) Land	r Foreign
poe	M. I		Usual Residence of Decedent 10a. State 10b. County	100	:. City, Town or Le	ocation				1	0d. Inside Cit	ty Limits
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di th	or 28	Directo	10e. Street and Number			10f. Zip Code	2	10	og. Citizen o		try?	
t died	ne 23e	Funeral	1015 Park Ave	Decedent Ever	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-		ace - Americ		
1215-0036	s 1 and 2 should be the willin 7.2 hours after death with the wasyan if Health and Menhal Hygiene. I them 27 is marked other than "natural", or itame 23a or 28a-1 show other traumatic event. If the Medical Examinar must be notified at	Ā	1 Never Married 2 Married 1	ed Forces? Yes 2 MgNo s.Give or Dates:		If Yes, specify Cuba 1 ☐ Yes ※XXNo	n, Mexican, Puerto Specify:	o Rican, etc.)		ack, White, ify: $B1$		
15-0036	n "natur	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	eted) ege (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of word)	king	16b. Kind of	Business/Ind	dustry	
CN 3	Hygiene Hygiene other the	Com	3rd	0	Tr	uck Dri					on Co	o
	Mental Hy Mental Hy arked oth atic even	To Be	17. Father's Name (First, Middle, Last) George Brown					ne (First, Middle, M 1 Green	Maiden Sumi	ame)		
lary Servi	and Menie marke		19a. Informant's Name/Relationship (Type, Print			ing Address (Street a						19
e, ≥	eand Health Im 27 thar tr		Dorothy Leonard (Da 20a Mathod of Disposition			Park An		apolis,	20c. Location			
nor	ages ant of I at: If Ita		1 Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State	Isantemie Memoria	osition (Name of grathery or other place) 11 Garde	^{⊕)} ns 5-3-	-06	David	sonv	ille,	Md.
Baltimore,	permit. Pages I am Department of Heal Important: If Item 2 eny injury or other once.		21. Signature of Funeral Service Licensee Lavoru B. Reose Mi	ns 492	W E	2. Name and Address Nm. Reese 321WEst	ss of Eacility Son	s Mortu	ary,	P.A. 2140		
	*		23a. Part1. Enter the disease, of complications to shock, or heart failure. List only one cause	that caused the				-			Approximate Interval Bet	ween
	hysician		Immediate Cause (Final disease or condition resulting in death)	Cara	liac:	trytim	10				Onset and I	Jean .
	/Medical Examiner		Du Du	ie to (or as a co	nsequence of):	1						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	e to (or as a co	nsequence of):							
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	ite be e iysician ne buria	100	d									
x 68	death certificate e attending phys id for use as the	/Med	IF FEMALE: 23c. If ye	s, outcome of p	regnancy				23d. [Date of delive	erv	U,
.O. Box	that the death certificate ed by the attending phy detached for use as the	by Physician/Medic	in the past 12 months?	Live birth 2 Pregnant at time Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)				J onth		Year
Φ.	og pe		Part II. Other significant conditions contributing	to death but no	ot resulting in the	underlying cause giv	en in Part I.	23e. Did tol	_/		ne cause of coably 4 🗆 t	
Records,	e law requir has been si ge 2 should	Completed						24a. Was a autops perforr	y	o. Were auto prior to co death?	psy findings mpletion of c	available ause of
_ '	ate pag	e Col	25. Was case referred to-medical				26 Place of Dea		No _	1 🗆 Yes	2 No	
f Vital	Physicia this cert al directe	To B	examiner? 1 Yes 2 No Hospital:	1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth	or /	lome 5□ Reside		ther (Specif	y)	
n of	ing Ph Viter th uneral		1 Natural 5 ☐ Pending	Date of Injury (Month, Day Ye	ar) 28b. Time (Wor		28d. Describe ho	w injury occ	urred		
Division	To the Hospital or Attending Physician: within 24 hours after dealt at the Funaral Director. After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - building, etc. (S	At home, farm, s	M 1	Yes 2 □ No	28f Location (Si City or Town		mber or Rura	al Route Num	iber,
Δ	To the Hospital or Attent within 24 hours after deatl to the Funaral Diractor: completely filled in by the		29a. Certifier Certifying Physician: (Check only 2 Medical Examiner: On	To the best of m	y knowledge, dea	th occurred at the time	ne, date and place	a, and due to the c	ause(s) and	manner as s	tated.	=1
:	To the He within 24 To the Fe complete	Medical	one) and title of certifier	manner stated.		29c. Licens			9d. Date sig			
	rsrö A.		· At			D	5702	8	05	103	100	2
	<i>'Y</i>		30. Name and address of person who completed	HUR	Suite	#231	Ann	apolis	SM	06	140	1
*	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 4 2006	32. Ré gistrar's	Signature	parts.						

06-02888 Shaheed Boyd		Please Type or Print in Black Indelible					
Silaneed Boyd		State of Maryland / Department of Health and Me 1-For Stanend Item//19a per fh C855er5/14/1960/@eath	ental Hyg		. 2	006	12975
Physici Medical Exami	an/	1. Deceded is Name (Firs), Middle, Last)	- 1	Reg Date of Death Month April 29, 20	Dav	Year 3	Time of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 4101 Elderon Avenue Baltimore City		- 		ity of Death	
Funeral Director		217-98-9016 XM 2 F 24 Yrs. Months Days Ho		8. Date of Birth	(MM/DD/Y)	YY) 9. Birthp Foreign Count	try) 1
yland -f show any once,	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Bullingre 10f. Zin Code				1	0d. Inside City Limits Yes 2 No
h the Mar 13a or 28s	Director	3110 Westmont Court 2121	6	100	Citizen of	What Country	•
after death with the Maryland II", or items 23a or 28a-f show ner must be notified at once,	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Process 12 Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, specify Cuban, Mexical Status 2 No Specific Process 12 No Specific Process 2 No Sp	an, Puerto Ric			hite_etc	n Indian, Black,
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary (Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	ve kind of wor OT use retired	k done	6b. Kind of	Business/Indi	ustry)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	å	Wayter BoyD Ro	zche	irst, Middle, Ma	incl	reste	er e
alga alga	은	to Christine BoyD 1701 W. Frat	St.	Apt./	05, B	W/D.A	12 2/223
MOFE Pages ent of H int: If i		20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify:	5-5	5-06	_	on - City or To	wn, State
Balti permit. Departm Importa		21 nature of Funeral Service Licensee 22 name and Ad re F c	Trick	wern		to MD	21223
Physician /Medical Examiner		23a. Part I. Er let the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each life. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to the Head Due to (or as a consequence of):	s cardiac or re	espiratory arres	t, shock, or	heart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					-
xecuted n and	Examiner	CDisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
a a a	edical	UNPENDED AMENDED					
Division of Vital Records, P.O. Box 68760, To the Hospital or Autending Physician: The law requires that the death certificate be within 24 hourst after death. To the Functors After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ector 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	pic pregnanc	у	23d. Date Month	of delivery Day	Year
cords, P.O. Bo. Iaw requires that the death has been signed by the an 2 should be detached for	و	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.			ntribute to the	cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the fare death. The Tree death. After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Completed			24a. Was an autopsy perform	ed?		sy findings available apletion of cause of
Vital ysician: his certifi director,	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4	th (Check only Nursing I		esidence (Other: Se	cene
on of anding Ph. Tr.: After to the functial	⊢	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work Day Year) 1 Natural 5 Pending Apr 29, 2006 1350 hrs 1 Yes 2	_ IDe	Bd. Describe ho		urred	
Division of Vital F Hospital or Attending Physician: 24 hours after death. Faneral Director: After this certifi tely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street		Bf. Location (Stror Town, Sta 01 Elderon	te)		Route Number, City
To the Hosp within 24 ho To the Fune	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manger stated	place, and du	e to the cause(s) and man	ner as started	
	We	29b. Signature and the of tentifier 29c. License numb O.C.M.E.	er		29d Date si April 30,	gned (Month, 2006	Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 2120)1			
Sí Regis	tate trar	31. Date filed (Month, Day, Year) MAY 0 4 2006 May 0 4 2006					
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The state of the s	
State of Maryland / Department of Health and Mental Hygiene	
Cartificate of Death	2006

nii Ailinoily B		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 200	6 13976
Physicia ledical Exami		1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death 0756 hrs
		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5522 Whitby Road 4c County of be Baltimore	ath
Funeral Director		Months Days Hours Min.	Birthplace (State or eign Country)
ith the Maryland 23a or 28a-f show any notified at once.	ctor	10a. State 10b. County 10c. City, Town or Location BALTIMORE 10g. Citizen of What City 10g. Citizen of What City 10g. Citizen of What City 10g. Citizen of What City 10g. Citizen of What City 10g. City	1 Ves 2 No
th the Ma 23a or 28 notified a	Il Director	5522 WHITBY RD. 21206 U.S.	A ·
r death w or items must be	by Funeral	3 Widowed 4 Divorced II Yes, Give Year 1 Yes 2 No specify. Specify.	1914 TE
36 hin 72 e. than "	Completed I		s/Industry 3/1= ROLL-OF
21215-0036 hould be filed within 7 and Mental Hygiene. is marked other than tire event, the Medics	o Be Co	B JOHN A. BUSCEMI LOLA M. RHEU	0
e, MD 2 1 and 2 shoul Health and N item 27 is n	ĭ	TOHWA BUSCEMT S503 NONTH POINT RD. BALTO 1 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery) Date, 20c. Location City	or Town, State
Baltimore, permit Pages I ar Department of Het Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee (/) 22 Name and Address of Facility 22 Name and Address of Facility	0. MD.
		Thomas Akara & SKARDIA F.H. 2029 HDDSCOT	21224
Physician /Medical Examiner		234. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death
	er	Sequentially list conditions b	
d d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
760, cate be executed physician and he burial - transit	Medical E	_	
		- 193h Was dependent assessed in the	ery Day Year
P.O. es that the signed by t	ē	1 Yes 2 No. 3 P	
of Vital Records, P.O. Box 68' and Physician: The law requires that the death certifi After this certificate has been signed by the attending meral director, page 2 should be detached for use as	Completed	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓	
Vital ysician: this certif	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Control of Death (Check only one) 1 Ves 2 No Control of Death (Check only one) 1 Ves 2 No Control of Death (Check only one) 1 Ves 2 No Control of Death (Check only one)	ner: Scene
ion of tending P eath. tor: After the funers	ation: T	27 Manner of Death 28a Date of Injury 28b Time of Injury 1996 Injury of Model Provided 1997	subject ingested
Division ppital or Attendir cours after death.	Certification:	3 X Suicide 6 Could not be determined (Specify) found in house 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 5522 White Baltimore, MD	Rural Route Number, City by Road
To the Hospital within 24 hours To the Funeral	Medical	29a Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as st 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to	arted the cause(s)
	Σ	Pater luon - Pollel no O.C.M.E. April 27, 2006	fonth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St Regist	ate trar	3/2/1 V D / 0000 L Fe	
DHMH 17 Rev 1/2			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 2, **Physician** Evelvn Ada Brosnan 2006 2:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Talbot. Easton Heartfields If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 ☐ M 2 💢 F 215-42-7114 Yrs. 1.02 09/09/1903 Maryland Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County Item 27 is marked other than "naturel", or Items 23a or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Talbot Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 4322 Old Stagecoach Road USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status parmit. Pages 1 and 2 should be filed within 72 hours after o Depertment of Health and Mentel Hygiene Important: If Item 27 ie marked other then "naturel; or Item eny Injury or other traumatic event, the Medical Exempted Once. Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Daniel James Stevens Martha Emma Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann Nilson Daughter 4322 Old Stagecoach Rd, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 05/05/2006 Elkridge, MD 23a Part 1. Enter the disease, promplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Us gony one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congretion

(1) ^{22. Name and Address of Facility} Gary L. Kaufman Funeral Home @ MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 Approximate Interval Between Onset and Death **Physician** 10 year /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2 ☐No been signed by the s should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s 2 No certificete 1 Yes or Attending Physician: funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 20 MG 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: Al investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0040274 llen Webb, M.D 2004 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8579 Commerce Da-Sule 100, EASTEN, MD 2149 I. Allen Webb, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Soule) Registrar MAY 0 4 2006

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month BENNING-TON MRISTINA 2006 APRIL 130 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Min. | Mar 13, 20 SCHROEDER AVENUE 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Director 6 Yrs. 2000 216-57-0686 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene, other then "naturel", or flems 23a or 28a-f ehow vent, the Medical Examinar must be notified at 1 ☐ Yes 21 No Director Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3814 Schroeder Street 21128 Funerai USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: bi-racial þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mentel h Richard Bennington 2 Tracy-Ann Marie Rowtham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Item 27 i Richard Bennington/father 3814 Schroeder Ave. Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H importent: if Ite any injury or ot ang.e. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S. Wades Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death EMBRYDING PHABDOMYDSARCOMA **Physician** METASTATIC year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificete has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 □ No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: : After this certific funeral director, 25. Was case referred to medical examiner? æ 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 3 Suicide 6 Could not be determined within 24 hours efter de To the Funerei Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time. Sale and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHMER MANY (an) 600 WILL AM SAINGE MD II. Ca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 4 2006 Registrar

			For State Registrar	State of Maryland		epartment of Certificate of				giene Reg. No.	006	13979
	Physicia		1. Decedent's Name (First, Middle, Las. James Travis	Bagley					Date of Dea Month	Day	2006	3. Time of Death 824 A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,		of Death	TPYIL		County of Deat	h
	Funeral Director		5. Social Security Number 6. Se		ast birtho	Months Davs	r If Unde	or 24 Hrs. 8	Date of Birt (Month, Day	y, Year)	9. Birt	hpface (State or Foreign untry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town o	or Location						10d. Inside City Limits
	ith the Marylan or 286-f ehow	ctor	MD	Bal	time	ore						1. Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code				10g. Citiz	en of What Co	untry?
	eath v	Funerai	6607 Elsrode Ave.	12. Was Decedent Ever in U.S	S	212		Origin? (Specif		USA	4. Race - Ame	rican Indian
220	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Heelin and Mental Hygiene. If item 27 is marked other than "netural; or iteme 23a or 28e-f ehow if item 27 is marked other than "netural; or item 27 is notified at or other treumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 152-5	ł	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ No			ean, etc.)		Black, White Specify: Whi	e, etc.
5	72 hoi neturi	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(0	ecedent's Usual Occu	e during mo	ost of working		16b. Kin	d of Business/	
7	within ene. then '	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	li	ife. DO NOT use retir eel Worker	ed) -			Ro+h	lehem	Ctool
2	at Hygie other vent,	Be C	17. Father's Name (First, Middle, Last)	iik j	0.0	CCI WOLKE	T	her's Name (F	First, Middle,			Preel
) Ja	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count coun	ToE	John Bagley					Mabel E				
D A	d 2 sh th and th and treum treum		19a. Informant's Name/Relationship (7 VA Medical Cente		1	Mailing Address (Street N. Greene						Zip Code)
lore,	permit. Pages 1 end 2 Department of Heelth s Important: if Item 27 is any njury or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Cremation 5 Months (Cremation 5 Months)			Disposition (Name of crematory or other pl		Date			ation - City or	Town, State
Daillino	permit. P Depurtme Importan any njuri		4 □ Donation 5 ☒ Other (Specify 21. Signature of Funeral Strice Licens Romal Ld S. V			22. Name and Add State Ana	tomy	Board	655 W.	. Bal	timore	Street
			23a. Parit. Enter the disease, or comp shock, or heart failure. List only	fications that caused the death	. Do no	Baltimore to the mode of dy	ving, such a	21201 as cardiac or r	espiratory ar	rest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Africation Due to (or as a consequ		eumonia						Onset and Death
	Examiner		Sequentially list conditions	b. Lactic Ac	dos	15						(day
	bed lsit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of)	:						
,00700	sicien and burial-tra	al Exar	that initiated events resulting in death) Last	c	ience of)	:						
00	ing phy e es the	Medical	IF FEMALE:	u.								
. DOX	he death or the attend ched for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death	3 Ectopic pregnan 5 Other (specify)				23	3d. Date of del Month	ivery Day Year
cords, F.	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions of	ontributing to death but not resu	ılting in t	he underlying cause g	liven in Par	t I.			e contribute to	the cause of death?
o S S S	The law rec te hes bee age 2 shou	Completed by								rmed?	prior to death?	utopsy findings available comptetion of cause of
N I G	entifice	BeC	25. Was case referred to medical examiner?				26. Pla	ce of Death (6		2□No ne)	1 163	2/2/140
	ing Physic After this couneral dire	2	1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outp 28b. Tin Inju	ne of 28c. Injury W	ury at ork?	286	5 Resid		Other (Spe	cify)
DIVISION	or Atteno	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				∐Yes 2[Location (S City or Tox		Number or Ru	ural Route Number,
_	Hospital 24 hours Funeral etely filled	edical Co	29a. Certifier (Check only one) Certifying Ph	ysicien: To the best of my knowiner: On the basis of examinate and manner stated.	ion and/	or investigation, in my	opinion, de	eath occurred	at the time,	date and	place, and due	to the cause(s)
	To th within To the	Me	29b. Signature and title of certifier	1		29c. Licer	nse numbe	r		29d. Date	signed (Mont	h, Day, Year)
			1000	My		10	186	00		Apri	128	, 2006
			30. Name and address of person who defreu Liu, M	completed cause of death (ftem	23a) (T	ype, Print)	Stean	+ Bal	Linua	mA	2/20	1
	Sta		31. Date filed (Month, Day, Year)	completed cause of death (fterm	ture	all &	1762	, 0:10	111101	,,,0		
	Registr	eli	MAY 0 & 2006	8 19 all 12 1 330	100	The state of the s						

			For State Registrar	State o	f Marylar		artmen rtificate			and M		leg. No	106	39	80
	Physici	an	1. Decedent's Name (First, Middle,								2. Date of Dea Month	th Day	Year	3. Time of 11:15	
	/Medic		Earl Samue		Bloom	Jr.					4	30	2006	11:13) AM
1	Examin	er	4a. Facility Name (If not institution,	•	mber)		,		Location of	of Death			unty of Death	7.	
			1615 BAY HEAD R	OAD S. Sex	7. Age (In yrs.	last birthday)	ANNA If Under		If Under	24 Hrs.	8. Date of Birth	1	ARUNDI 9. Birtho		r Foreign
	Funeral Director		212-24-7847	1/ ZY 2□ F	78	Yrs.	Months	Days	Hours	Min.	(Month, Day SEP. 4,	, Year)	MD	lace (State o	, r o o o gri
	p.		Usual Residence of Decedent												
	anylar ehow	1	10a. State 10b. County		10c. C	ity, Town or Lo	ocation						1	0d. Inside Cit 1 Tyes	•
	Ba-f	ecto	MD ANNE AR	UNDEL	ANN	APOLIS	T 4 04 701								- LANG
	ath with the Marylan 8 23a or 28a-f ehow	Funeral Director					10f. Zip						of What Cour	itry r	
	eath	era	1615 BAY HEAD RO		edent Ever in U	J.S. 13.	214		spanic Ori	gin? (Sp	ecify Yes or No-	USA 14.	Race - Americ	an Indian.	
0	r Ken	핊	1 Never Married 2 XMarrie	Armed Fo	orces? 2 ∏ No					i, Puerto	ecify Yes or No- Rican, etc.)		Black, White,		
2-0036	hours after death with the Maryland lural', or liems 23a or 28a-f ehow al Exartal nursual be notified at	l by	3 ☐ Widowed 4 ☐ Divorced	lf ₹ēs , Gi Year or D	ve ates:		1 ☐ Yes	2 La-No	Specify:			Sp	ecify: WHIT	ľE	
2		Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	d Occupa	ation Ju <i>ring m</i> os	t of work	ing	16b. Kind	of Business/In	dustry	
12	within 72 ene. than "na	mp	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	CARPE		se retired,)			CARPE	NTDV		
27	filed v Hygie other t		17. Father's Name (First, Middle, L.	ast)		CARLE	NIEK		18. Mothe	r's Nam	e (First, Middle,				
an	Aental Aental rked o	To Be	EARL SAMUEL BLOC					İ	EILE				,		
Maryland	should by nd Menta i marked umatic ev	-	19a. Informant's Name/Relationshi			19b. Maili	ng Address	(Street a			al Route Numbe	r, City or To	wn, State, Zip	Code)	
	elth a elth a 27 is		MRS. JOSELENE BL	OOM/ WIF	E	1615	BAY	HEAD	ROAD	ANN	NAPOLIS,	MD 2	1409		
Baltimore,	permit. Pages I and 2 should be Department of Heelth and Menta Importent: If Item 27 is marked any injury or other traumatic es	1	20a. Method of Disposition	2 Demoved from		Place of Dispo cemetery, cre			9)		Date		ion - City or To		
Ĕ	Pages ment of ent: If its ury or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other Spe			N HAVE	N MEM	. PA	RK M	IAY 3	3, 2006	GLEN	BURNIE ,	, MD	
<u>a</u>	Departi Departi Import any inj		21. Signature of Pureral Service Li	tensee			2. Name an				HOME, P.	۸ 1	SECONI	AVE	c ti
8760,	Physician /Medical Examiner	dical Examiner	23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to	each tine.	quence of):	ter the mod	e of dying	g, such as	cardiac	or respiratory are	est, GLE,	N BURN	Approximate Interval Belv Onset and D	ween
.O. Box 6	The law requires that the death certificate be executed ete hes been signed by the ettending physician and page 2 should be detached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 Fet nant at time of	al death 3	Ectopic pro					23d.	Date of detive	-	'ear
Records, P	signed b	۵	Part II. Other significant condition	es contributing to d	eath but not re	sulting in the u	nderlying c	ause grve	n in Part I.		23e. Did to	bacco use	contribute to the	ne cause of do	
Š	w requir been si should	lete									24a. Was a	ın 2	4b. Were auto	nev findings	available
	ysician: The lav is certificete hes director, page 2	Completed	11.							_	autop: perfor	sy	prior to cor death?	npletion of ca 2 No	ause of
Vital	Attending Physician: The death. sctor: Alter this certificete by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		1		Othe			h (Check only or				
ō	£ ≑ ਢ	5	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b, Time o		A	4 🗆 Nu		me 5 Resid			1)	
O	ding fith. : After s funer	to	Natural 5 Pending 2 Accident investiga	to the second	th, Day Year)	Injury	М	8c. Injury Work 1 ☐ Y	:? ∕es 2 🔲 I	No					
Division of	<u>, 2, 3, 0</u>	ertification;	3 Suicide 6 Could no 4 Homicide determin	and 289. Place	of Injury · At h	nome, farm, str ify)	reet, factory	r, office			28f. Location (S City or Town	treet and N n, State)	umber or Rura	l Route Numb	ber,
	e Hospital 124 hours e 16 Funerei L	Medical C	29a. Certifier (Check only one) Certifying Certifying	Physician: To the xaminer: On the band man	best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurred vestigation,	at the tim	e, date an pinion, dea	d place, th occur	and due to the cred at the time, d	ause(s) and late and pla	d manner as st	ated. the cause(s))
	To the Ho within 24 To the Fu	Me	29b. Signature and title of certifier	1 2	/) _	4_	290	. License	number	-	120- 2	9d. Date si	gned (Month,	Day, Year)	14/
	h		TOU CU	101	rein	1 4 m	Juca .	1	/	110	138	11/1/	4 0	1, 20	46
	12		30. Name and address of person	G CO THE CAUSE	se of death (Ite	m 23a) (Typa,	Print)	FER	JSE 1	46,	HWAY	ANI	VAPULIS	M92	140/
	Sta Registr	10000	31. Date filed (Month, Day, Year)	2006 32.	legistrar's Sign	ature	00/60	**			6				

	1	For State Registrar		rtment of Health and tificate of Death	Reg. N	2000 13201
Physicia /Medica	เท	Decedent's Name (First, Middle, Last) Robert Brociou	S			Year 3. Time of Death 11:35 A M
Examine	er	a. Facility Name (If not institution, give street an University of Mayland N	Medical Center	4b. City, Town, or Location of Dea Baltimore		c. County of Death
Funeral Director		5. Social Security Number 163-32-2163 Sual Residence of Decedent	7. Age (In yrs. last birthday) F 65 Yrs.	Months Days Hours Min		
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itsm 27 is marked othsr than "natural, or itsms 23s or 28s-f show or other traumatic svant, Its Medical Exertinar must be notified at	-	MD Anne Arunde	10c. City, Town or Los 1 Glen Bu		10g. C	10d. Inside City Limits 1 □ Yes ②□No
after death with	a	1 Never Married 2 Married 1 □	ed Forces?	21061 Was Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	Specify Yes or No- nto Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: white
thin 72 hours a e. sn "natural", c Medical Exar	Completed by	3 Widowed 4 Divorced Year 15. Decedent's Education (Specify only highest grade comple	or Dates: 16a. Deced (Give life. L	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	Kind of Business/Industry
be filed will stal Hygien od other th svsnt, Ital	Be	12 17. Father's Name (First, Middle, Last)			me (First, Middle, Maide	
d 2 should th and Men 7 is marke traumatic	ပ	LAWRENCE 19a. Informant's Name/Relationship (Type, Print Dorothy J. Brocious /		Heler ng Address (Street and Number or F Charles Avenue;		y or Town, State, Zip Code)
permit. Pages 1 and 2 Department of Health a Important: if itsm 27 is sny injury or other traing 2006.		DOPOCHY J. BFOCTOUS / 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State 20b. Place of Dispo cemetery, cren Cedar Hil	sition (Name of natory or other place)	Date 20c. 2/2006 B1	Location · City or Town, State ${ m cooklyn}$, ${ m MD}$
permit. Departr Imports sny inj		1 100 9-000	MO1364 1	Name and Address of Facility S Second Ave. SW	Glen Burni	
Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	yo cardial Te to (or as a consequence of):	nfarction	ac or respiratory arrest,	Approximate Interval Between Onset and Death
the death certificate be executed y the attending physician and sched for use as the burial-transit	Physician/Medical Ex	d IF FEMALE: 23b. Was decedent pregnant in the past 12 months?]Ectopic pregnancy □ Other (specify)		23d. Date <i>of</i> delivery Month Day Year
ires that the de signed by the a d be detached	by		Unknown			o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Nnknow
: The law requires that cate has been signed b page 2 should be deta	Completed				24a. Was an autopsy performed/	
To the Hospital or Attending Physician: whithis 24 hours after death. To the Funeral Director. After this certification that principle is not be the funeral director.	Certification: To Be	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	Date of Injury (Month, Day Year) Place of Injury - At home, farm, str	nt 3 DOA Other: 4 Nursing f 28c. Injury at Work? M 1 Yes 2 No	eath (Check only one) Home 5 Residence 28d. Describe how in	njury occurred and Number or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in b		29a. Certifier 12 Certifying Physician:	building, etc. (Specify) To the best of my knowledge, deal the basis of examination and/or in	h occurred at the time, date and pla	ce, and due to the cause	e(s) and manner as stated.
To the P within 24 To the F complete	Medical	29b. Signature and title of certifier	manner stated.	29c. License number P19795	29d. I	Date signed (Month, Day, Year)
0 '		30. Name and address of person who completed Penali Naticewala	d cause of death (Item 23a) (Type, University of W	Print) Lanyland Medica 5. Greene Stre	Center Det Baltimor	ept. Internal Medic C, MD 21201
Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 2006	32. Gegistrar's Signature	conti		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year John C. Cremins **Physician** 6:10 Ам 04/22/2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F 1.06-30-8981 Director 98 Ireland 11/03/1907 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f ehow "natural", or items 23a or 28a-f ehov olical Examinar must be notified at MD Elkridge 1 ☐ Yes 2√ No Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8100 Arbor View Way 21075 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. withIn 72 hours efter 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced permit. Peges 1 and 2 should be filed within 72 hc Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "natur any injury or other treumatic event, Ite Madical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer 9 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Clemins Julia O'Dwyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Cremins / Wife 8100 Arbor View Way, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Media Cemetery 04/25/2006 Media, PA 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 21. Signature of Funeral Service Licenset M01378 7250 washington Blvd., Elkridge, MD 21075 or cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disable hick, or heart failure. mediate Cause (Final Physician Yneumia isease or condition sulting in death) /Medical Due to (or as a consequence of): respirator 4 **Examiner** leadin Sequentially list conditions, Dise to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, burial-transi the attending physicien and resulting in death) Last Due to (or as a consequence of). by Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 V Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural Injury 5 Pending death. 1 🗌 Yes 2 🗌 No 2 ☐ Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 4/24/0 10053709 alu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raj Chawla 14300 Gallant Fox LN., Suite 210, Bowie, MD 20715 31. Date filed (Month, Day, Year) 32/Registrar's Signature State MAY 0 4 2006 Registrar

			For State Registrar	State of Maryland		artment of H		lental Hy	giene Reg. No.	LIUb -	13983
			1. Decedent's Name (First, Middle, La.	st)				2. Date of De	eath		3. Time of Death
	Physici /Medio		Marion Col	ien				Month May	Day	2006	11:00A M
j.	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. (County of Death	
			5809 Key Avenue			Baltimo					
	Funeral Director		310-22-7905	ex	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, D. Aug. 6	ay, Year)	Cou	place (State or Foreign ntry) ndiana
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation				1.	10d. Inside City Limits
	Manyl f eho	៰		,							1X Yes 2 □ No
	28a-	Director	MD 10e. Street and Number		Balt	imore 10f. Zip Code			10n Citiz	ten of What Cour	
	3a or	٥	5809 Key Avenue			2121	<i>F</i>		rog. Omi		
	death me 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or N	0- 1	USA 4. Race - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow supprintury or other traumatic event, the Medical Exarting missible incitiled at ances.	호	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 <mark>X</mark> No	n, Mexican, Puerto Specify:	Rican, etc.)		Black, White, Specify:	etc. Thite
ğ	2 ho	Completed	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occupa	ition		16b. Kin	nd of Business/In	
7	thin 7	nple	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	luring most of work)	ing			
7	or th	ő		1	E	ookkeeper	•		Wels	sh Remod	leling
2	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	, Maiden S	Sumame)	o .
<u>\}</u>	ould Men Marke	မ	Nicholas G. Brus				Anna				
<u>a</u>	12 sh and 1s m	1 15	19a. Informant's Name/Relationship (ng Address (Street a					
e)	1 and 1ealth 1m 27 ther t		Dolores S. Mazza 20a. Method of Disposition	rella Sister	9108	Sandra Co	urt, Ran	dallsto Date			
Baltimore,	in its		1 X Burial 2 ☐ Cremation 3 ☐	II IGIIIOVAI II OIII SIAIG		sition (Name of natory or other place	1		200. Loc	cation - City or To	own, State
<u>=</u>	rtmer rtant njury		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer			n Cemeter				ltimore	
Ba	Depareimpor importent in portent		21. Signature of Futheral Service Licer	m and	/-	Name and Addres					town Road
	_		23a. Part1. Enter the disease, or com	plications that caused the death.		line Fune				rstown,	MD 21136 Approximate
			shock, or heart failure. List only Immediate Cause (Final	on each line.	0	1 0	g, odon do odralao	or respiratory t	111031,		Interval Between Onset and Death
1	Prrysician /Medical		disease or condition resulting in death)	a. De lo as a conseque	ry	dami	re.				
	Examiner			Se of as a conseque	ince on:	Olde m	9440				
Ą	- St	ē	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ince of):	CELEGICAL III	20174				
1	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	C.							
o o	en ar en ar irial-ti		resulting in death) Last	Due to (or as a conseque	nce of):						
8760,	ate be nysici he bu	dicai		d							
		Med	IF FEMALE:							1	
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 pronths?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d	eath 3	Ectopic pregnancy			2	3d. Date of delive Month	ery Day Year
o.	the e	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknow	4☐ Pregnant at time of dea 9☐ Unknown	th 5	Other (specify)					ou, rou
مــَ	Attending Physicien: The law requires that the death certific rideath. - ctor: After this certificate has been signed by the ettending put the funeral director, page 2 should be deteched for use as by the funeral director.	Completed by Physician/Me	Par II Other significant conditions of	ontributing to death but not result	ing in the u	nderlving cause give	en in Part I.	23e. Did	tobacco us	se contribute to the	he cause of death?
Division of Vital Records,	uires r sign ld be	d b	(Somara)	Astery Do	reco	re		1/2	Yes 2□	No 3☐ Prot	oably 4 Unknown
Š	w req beer shou	lete	the aga de	50000.0				24a. Was	20	24h Word auto	anney findings available
æ	Physicien: The lav this certificete has al director, page 2	Ę	my my	-0114	, P	Λ.	. 1	auto		prior to co death?	ppsy findings available mpletion of cause of
<u>a</u>	ifficet or, pe	اده	25. Was case referred to medical	3624mcsm	e 10	Manner of the second	26. Place of Deatl	Yes Charles	2 No	1 🗆 Yes	2 No
5	ysicie s cert direct	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ El	R/Qutpatier	t 3 DOA Othe		1/		Other (Specif	541
ਰ	9 Ph er th	2	27. Manner of Death		8b. Time o			28d. Describe			<i>y</i> /
<u>ö</u>	ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 Accident investigation		Injury		res 2 □ No				
N X	er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, str	eet, factory, office			(Street and	Number or Rura	al Route Number,
٥	ital or rs eft ai Di	Certification:		Straing, Stc. (Specify)				Only of 10	, Jia 18/		
)	To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) Cartifying Ph	ysician: To the best of my knowl niner: On the basis of examinatio and manner stated.	edge, deatl n and/or in	o occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the red at the time.	cause(s) a date and	and manner as s place, and due to	tated. the cause(s)
	To th within Fo th	Me	29b. Signature and the of certifier	4. 10 1		29c. License	number		29d. Date	signed (Month,	Day, Year)
}	/		· (Ille	M Delle		Da	4808		MA	V21	2006
	5		30. Alarmound address of person who	completed cause of death (Item 2	(Type,	Print)	10-0	4:0	221	1 21-	>> 0
_)		Hentru	Inen 18?	386	seeme to	coe#17	35 P20	ST N	MOD A	908
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	4					
	Registi		MAY 0 4	2006 /	1	000150					
DHN	MH 17 Rev 1/2	001		2	1	IA I A I					
					ORIG	INAL					

1 = For Stata Ragistrar	State of Maryland / Dep Ce	artment of Health and M rtificate of Death		ene g. No.	13981
1. Decedent's Name (First, Middle, Lician Julia Ringgold C			2. Date of Death Month	Day Year 1 2006	3. Time of Death
niner 4a. Facility Name (If not institution, gu 13801 Pleasantvi	ve street and number)	4b. City, Town, or Location of Death Baldwin		4c. County of Death	
5. Social Security Number 6. 212-24-8649	Sex 7. Age (In yrs. last birthday, 1 M 2 F 79	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	Year) 9. Birth Con 1926 M	pplace (State or Foreign intry) D
Usual Residence of Decedent 10a. State 10b. County MD Baltim	ore Baldwir				10d. Inside City Limits 1 ☐ Yes 2X No
MD Baltim 10e. Street and Number 13801 Pleasantvi	lle Rd.	10f. Zip Code 21013		g. Citizen of What Co USA	untry?
10a. State 10b. County MD Baltim 10e. Street and Number 13801 Pleasantvi 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest generally Secondary (0-12)) Elementary/Secondary (0-12)	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify:	
15. Decedent's l (Specify only highest g	rade completed) (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	king	6b. Kind of Business/I	
o 17. Father's Name (First, Middle, Las		18. Mother's Nam Bernadine	ne (First, Middle, Ma e. Donahue		•
P Arthur John Rin 19a. Informant's Name/Relationship	(Type, Print) 19b. Mail	ing Address (Street and Number or Ru	ral Route Number, (City or Town, State, Z	
Ted Cypull/hus	20b. Place of Disp	801 Pleasantville R		Oc. Location - City or	
1 XBurial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	ify) Dulaney	Walley Memorial C	ardens T	imonium,	MD 21093
1 XBurial 2 Cremation 3 4 Donation 5 Donation (Spec	J. Flagle	2. Name and Address of Facility Lemmon Funeral H 0 W. Padonia Rd.	lome of D , Timoniu	Oulaney Va um, MD 21	lley, Inc. 093
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. Do not end on the control of the cause on each line. a	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	(
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Pro 9 Unknown Part II. Other significant conditions		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
	contributing to death but not resulting in the	underfying cause given in Part I.	23e. Did toba	acco use contribute to	
Completed			24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
25. Was case referred to medical examiner? 1 Yes 2 40	Hospital:	Other	ome 5 Residen	nce 6 Other (Spec	cify)
27. Manner of Death 27. Manner of Death 1 Death 2 Death 1 Death 2 Death 3 Death 1 Deat	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how		
27. Manner of Death Death Death Statural Statu		treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
27. Manner of Death 1	Physician: To the best of my knowledge, dea aminer: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
29b. Signature and title of certifier	ugan Oucologist	29c. License number D 0056 91 9	29	d. Date signed (Month $65/02$	4
/	pleted cause of death (Item 23a) (Type		les St., I		
State 31. Date filed (Month, Day, Year)	32. Registrar's Signature	all 8			

State of Maryland / Department of Health and Mental Hygiene | | - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 **Physician** George Christopoulos May 1:22 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year)
Dec. 12, 1 Birthplace (State or Foreign Country)
 Greece **Funeral** Days Hours 1 XX 2 □ F Months 361-01-6650 96 Yrs. Dec. Director 1909 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiane. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "naturel", or iteme 23a or 28a-f show vent, the Medical Examiner must be notified at XXYes 2 □ No Maryland N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 W. 37th Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐XNo Specify. þ Specify: white 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bartender Food/Beverage 6t.h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be file Depertment of Heelth and Mentel Hy Importent: if flem 27 is marked oth eny liquy or other treumstic event one. Christos Christopoulos Fotini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandra Christopoulos Wife 1210 W. 37th Street Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Varial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cemetery 5/5/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 2121123a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death ed by the e 5 Other (specify) 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown cete hes been si 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete 2 No 1 ☐ Yes To the Hospital or Attending Physicien: ; Aftar this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ₩No ို 1 Inpatient 2 PER/Outpatient 3 DOA Siu 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Tes 2 No 2 Accident i Director; d in by the 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide within 24 hours a Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier 29b. Signature and title of defitier 29c. License number 29d. Date signed (Month, Day, Year) 000e I bnapathu

Registrar DHMH 17 Rev 1/2001

State

Soumya

31. Date filed (Month, Day, Year)

MAY 0 4 2006

Goode

Unian

MD

32. Registrar's Signature

30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Ganapathy

		4	For State Registrar	State of Maryl		artment of F rtificate of			jiene leg. No.	06	13986
	1.0		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea		V	3. Time of Death
	Physici /Medic		BENJAMIN			COHEN		APRIL	30 ^{Day}	2006	11:04 P M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of Deat	h	4c. Co	unty of Death	h
		- 46	NORTHWEST HOSPITA	AL CENTER		RANDALL	STOWN		BAL	TIMORE	
	Funeral		Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min				hplace (State or Foreign untry)
1	Director		212-44-0840	X 2 F 6	1 Yrs.			01/03/19	945		EGYPT
	pue *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation					10d. Inside City Limits
	eho	5	MD BALTIM		BALTIMOR						1 ☐ Yes 2 🛣 No
	28s-i	ect	10e. Street and Number			10f. Zip Code			Ina Citizen	of What Co	
	with Be or	Funeral Director	130 SLADE AVENUE	ADT #207			21208				uy.
	ne 23	era	11. Marital Status	12. Was Decedent Ever	in U.S. 13.			Specify Yes or No-		S.A.	nican Indian,
"	riter	Fun	1 X Never Married 2 Married	Armed Forces?		Was Decedent of H If Yes, specify Cub		to Rican, etc.)		Black, White	a, etc. HITE
9	ours after death with the Marylan ral', or iteme 23a or 28a-f ehow Examiner must be notified at	by	3 Widowed 4 Divorced	ff Yes, Give A Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Sp	ecify:	11111
0-0	72 hours after death with the Maryland "natural", or Iteme 23a or 28e-f ehow idical Exprimer must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	pation	urkina	16b. Kind	of Business/I	Industry
21	within and the second s	ple	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life.	DO NOT use retire	d)	, kang			
2	il Hygiene. other then	S		5	COMPU	TER ANALY				PUTERS	S
nd	be filed within 72 ho ital Hygiene. id other then "natur event, the Mod Fall	Be	17. Father's Name (First, Middle, Last,)	CO	ELE N		me (First, Middle,	Maiden Sui	mame)	EL CAMTI
yla	2 should be and Mental is marked c	ဥ	JOSEPH		CU	HEN	RACHEL	•			ELGAMIL
Maryland 21215-0036	and is m	1	19a. Informant's Name/Relationship (1	ng Address (Street					
	s 1 and f Health item 27 other tr		JACOB COHEN / BRO			PRAIRIE	ROSE PLA				
9	S		20a. Method of Disposition 1 D Burial 2 Cremation 3 C	Removal from State		matory or other pla		Date		ion - City or 1	
Ë	ertmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specif		ETH TFIL			03/2006 W			
Baltimore,	permit. Pege Depertment of Important: if eny injury or once.		21. Signature of Funeral Service Licer	nsee		2. Name and Addre					
-	0 D = 0		10000/0							ILLE,	MD 21208
- C			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.			ng, such as cardia _	c or respiratory arr	est,		Approximate Interval Between
	Physician	1	fmmediate Cause (Finaf					,			
			disease or condition	a Arteniosc	lesotic	Cardiou	ascular	Diseas	ie.		Onset and Death
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7	/Medical Examiner	xamlner	disease or condition	b. Due to (or as a cor	nsequence of):	Candiòu	ascu la	Diseas	ie.		_
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Vernette Dove May 2006 1705 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 10 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral**) 1953 Country 1 M 2 X 52 Yrs. 220-66-5982 Director Usual Residence of Decedent with the Maryland 10b. County 10a State 10c. City. Town or Location 10d, Inside City Limits r than "naturel", or Iteme 23s or 28e-f show The Medical Examiner must be notified at Maryland Anne Arundel Annapolis XXYes 2 □ No Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 701 Glenwood St. Apt. 707 21403 USA death by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Item any injury or other traumatic event, the Medical Examinat once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Elementary/Secondary (0-12) Colfege (1-4or 5+) Food Service Attendant Medical Center 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Dove Cynthia Raikes 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Greenbriar Lane Annapolis, Md. 21401 Rochelle Harris(Daughter) 20b. Place of Disposition (Name of Bersely Charles) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-8-06 Memorial Park Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wm. Reese & Sons Mortuary, P.A. Treese MOOY 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner S quentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a Was an cate has l page 2 s 2 No certificate: 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural fniury 5 Pending death. 1 Tes 2 No Director: / 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direct 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29b. Signature and title of certifier 153306 ann MO 30. Name and address of person wife completed cause of death (Item 23a) (Type, Print) 900 Bestoute Ld Annapolis in Harris ms 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAD Physician Menth Day Year 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SON SECOURS HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1□M 2\ F Yrs. Director 218-76-7969 63 4-9-1943 VIRGÍNIA Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h Counts 10c. City, Town or Location 28a-f show 77 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at 1 XYes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1917 CLIFTON AVE. 21217 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iten any injury or other traumatic event, the Madical Examinar, one. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0--0-DISABLED DISABILITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS STONE MARY STONE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOSEPHINE DUCKETT (FRIEND) 1917 CLIFTON AVE. BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specity) MT. ZION CEMETERY 5-4-2006 BALTIMORE, MARYLAND THE ALL HOME, P.A. 21. Signatura 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death RESPIRATORY FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner EPSIS Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed NEUMDNIA resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by RENAL FAILURE 3 ☐ Probably 4 ŽUnknown CERE A POVASCULAR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an SEIZUNE 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□No ဥ 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident ector: by the 3 ☐ Suicide 6 ☐ Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and v- moon beli, m D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAGIMONE MD 21223 V. MOSHSEYIMD 2000 W. BANTIMORE 87., 31. Date filed (Month, Day, Year) 32. Angistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] [6] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May Month **Physician** 2006 Alfred James Eves Рм 9:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 MM 2□ F Months Hours Yrs. Director 196-05-1408 88 1918 Pennsylvania FEB 28, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show 1 Yes 2 XNo Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8415 Bellona Lane, Apt. 311 21204 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Metallurgist permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien important: if item 27 I a marked other the eny injury or other traumatic event, Ltt. 0006. Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl Eves ဥ Jenny Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Quaker Ridge Road Janice N. Eves-Lopez, daughter Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 05/03/06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ischemic Cardiamorathy disease or condition resulting in death) years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sicien and burial-transit The law requires that the death certificate be executed that initiated events Records, P.O. Box 68760, 4 resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the nding r IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? certificate has the 2 \ No 1 TYAS Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D58303 3 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. CHARLES STREET AARON J. CHARUES, MO TOWSON MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAY 0 4 2006

	•	For State Registrer	State	of Maryla		artment of F rtificate of		nd Mental	Hygie Reg.	/ 11	06	1399
		Decedent's Name (First, Middle	e, Last)						of Death		.,	3. Time of Death
Physicia		Mary	Evan	isko				Apri		Day 2006	Year	11.15P M
/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of		1 24	4c. County		<u> </u>
Examin	er	Southern Mary			nter	Clinto	n			Princ	o Co	orge's
Europal		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date	of Birth			
Funeral Director		156-03-2347	1□M 2 X]F	85	Yrs.	Months Days	Hours	Min. Feb	h, Day, Ye	7921	9. Birthi	ntry)
	-	Usual Residence of Decedent		1								
Mo to		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
무별	ţō	Maryland Prince	George's			Upper	Mar1bo	oro				1 ☐ Yes 2√√No
Hygiene. other than "natural", or Itams 23s or 28s-f show ent, the Medical Examinar must be motified at	Directo	10e. Street and Number				10f. Zip Code			10g.	Citizen of \	What Cou	ntry?
lo ag		11308 Capstan	Drive			2077	2			U.S.A		
18 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in l	U.S. 13.	Was Decedent of H	Hispanic Orig	in? (Specify Yes	or No-			can Indian,
直蓋	ᆵ	1 Never Married 2 Mar	Armed F ried 1 ☐ Yes	orces? 2XXNo		If Yes, specify Cub		Puerto Rican, et	c.)	1	ck, White,	
0, 1	þ	3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	If Vas G	ive		1 ☐ Yes 2 ☒ No	Specify:			Specify	v: Whi	ite
a E		15. Deceder	t's Education		16a. Dece	dent's Usual Occup	ation		161	o. Kind of B	usiness/In	dustry
a tra	Completed		st grade completed		(Give	kind of work done DO NOT use retire	during most d)	of working				
that.	E	Elementary/Secondary (0-12) 8th	College	(1-4or 5+)		Homemaker				Hom	e	
The Hyg	Ö	17. Father's Name (First, Middle,	Last)				T	's Name (First, A	liddle, Mai			
la de co	Be c	Paul Chup	ka				Ka	atherine	Ri	bar		
D Tark	2	19a. Informant's Name/Relation:			19h Maili	ng Address (Street	·				State. Ziu	Code)
7 ts 1					i							
healt her	1	Philip Evanisk	o (Son)	20h						c. Location -		VA 22311
0 = 0		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from	State To	cemetery, cre	sition (Name of matory or other pla	ce) P	Apri ^D ate 27 2006	,			aryland
ent:		4 □Donation 5 □Other (S		Lee	e Crema	tory		2006		STIHLC)11, F1	aryianu
Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic avent. The Medical Examinar must be notified at once.		21. Signature of Funeral Service	Licensee	40019		2. Name and Addre	ess of Facility Id Ale	xandria	Ferr	y Road	Cli	nton, MD20
nysician Medical kaminer the private transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	O (or as a conse	equence of): Luci	mon nuà longo tie 3	lyse	7				Conset and Death Wolfon on a London on a L
ed by the ettending ph detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12,months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐Live	utcome of pregr birth 2 ☐ Fe gnant at time of nown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у				te of delive	ery Day Year
ned l	by P	Part II. Other significant condition	ons contributing to	death but not re	esulting in the t	inderlying cause gi	ven in Part I.	23e	Did tobac	co use conf	tribule to t	he cause of death?
should be	ğ	gungalen	re Both	Fe	et				1 🗌 Yes	2 🗆 No	3 Pro	bably 4 Ahknow
sho	Completed							24a	Was an	24b.	Were auto	opsy findings available empletion of cause of
e hes	m.								autopsy performed	d?	death?	
ficet or. pe		25 Was case referred to modes	1				OF Diago			10	1 🗌 Yes	2 LI NO
certi	Be c	25. Was case referred to medical examiner?	Hospital	Nanotinet C	7 5 8 7 5 5 5 5	at all por Ot	hor	of Death (Check			nor /0-	4.1
rathis rath	5	1 Yes 2 16	28a. Date		☐ ER/Outpatie 28b. Time o	nt 3 DOA	4 🗆 Nui	rsing Home 5 28d. Des		injury occur		(17)
After fune	io Lo	1 ☐ Natural 5 ☐ Pendi		nth, Day Year)	Injury	Wo	rk?]Yes 2 □ N					
ter death Irector: n by the	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At ding, etc. (Spec	home, farm, st	reet, factory, office		28f. Loca	tion (Street or Town, S		ber or Rur	al Route Number,
within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page		29a. Certifier Certifyi	ng Physicien: To the	ne best of my kr	nowledge, dea	th occurred at the ti	ime, date and	d place, and due	to the caus	se(s) and ma	anner as s	stated.
n 24 he F	edical	one)		nner stated.			نام	social ou at title				
To t	Σ	29b. Signature/and title of count	Fr /			29c. Licen	se number			. Date signe	0	
,		V/L/V	2			57	45	4	A	PRI	1,2	6,06
, 6		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type			1		- '	/	
(1)		Arastoo Yasda				Rd. # 35	50 F+	Washing	ton	Md 2	0744	
Sta Registr		31. Date filed (Month, Day, Year		Pegistrar's Sign	nature	Corle	<u> </u>	"doning	<u></u>	2	V/ 7.7.	

		١	1 - For State Registrar	State of Mary		artment of F rtificate of		Menta	al Hygien	UUU	13992
į,	Thurs.		Decedent's Name (First, Middle, La.	st)					te of Death		3. Time of Death
	Physicia /Medic		Margaret	С.	F	razzitta			ril 29	^{ау} 2006	8:00 A M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, c	r Location of Dea	th	4	c. County of Dea	th
		ě.,	200 Giddings Ave				rna Park				rundel
*.	Funeral		5. Social Security Number 6. S	□M 257 F	yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (M	te of Birth onth, Day, Yea	9. Bird Co	thplace (State or Foreign buntry)
學下	Director		213-12-8420 Usual Residence of Decedent		87 Yrs.		<u></u>	Ap	ril 29,	1919 Ma	aryland
	yland		10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside City Limits
	Mar-f st	tor	Maryland Anne	Arunde1	Severna	Park					1 ☐ Yes 2 🗷 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?
	23a 23a	aic	200 Giddings Ave.				146			U.S.A	Α.
	tame	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puei	Specify York nto Rican,	es or No- etc.)	14. Race - Ame Black, Whit	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:			Specify: 1	White
Ş	filed within 72 hours after death with the Maryland Hygione. Iffer then "natural", or Iteme 23a or 28a-f show int, the Macalcal Examiner must be notified a		15. Decedent's Ed	l	16a, Dece	ident's Usual Occup	ation		16b	Kind of Business	
15	n "na	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of wo	orking	100.	Time of Buomoou	in addity
212	d with piene r the	Eo	Elementary/Secondary (0-12)	College (1-4or 5+) N/A		Homemaker				Own Hor	no.
b	e file ofhe vent,	Bec	17. Father's Name (First, Middle, Last)			HUMEMAKEI	18. Mother's Na	ıme (First	Middle, Maide		
/lar	should be and Mental marked o	TOE	Charles	В.	Bi1z	er	Katheri	ne	Н.	F	Healy
a	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Merital Hygiene. The marked other then "natural", or Itame 23a or 28a-f show other traumatic event. The Marital Examiner must be mailified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street	and Number or R	lural Rout	e Number, City	or Town, State, 2	Zip Code)
≥	and ealth m 27		Caroline F. Hem				a Ave. Se				
Baltimore, Maryland 21215-0036	0 0 = =		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	1	Ob. Place of Disp cemetery, cre	osition (Name of matory or other plan	ce)	Date	20c. l	Location - City or	Town, State
Ē	Pag tment tant: jury		4 ☐ Donation 5 ☐ Other (Specification)	()		Crematory		/06	Ba	ltimore,	Maryland
gail	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	see		2. Name and Addre	,	Fune	ral Hom	РΑ	
rof by	40 = 8 A		grand 1	ollin		McCully-P 3204 Moun				Maryla	
72			23a. Part1 Enter the disease, or com shock, or heart failure. List only	one cause on each line.	death. Do not en	ter the mode of dyir	ng, such as cardia	ic or respi	ratory arrest,		Approximate Interval Between Onset and Death
95. 84.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pancrea	tic Ca,	nces					
	Examiner			Due to (or as a con	nsequence of):						
		ē	Sequentially list conditions,	b. Due to (or as a por	(to concurs an						
$\sqrt{}$	uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury								
·	exection and ital-tra	Exa	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):						
8760	ıcate be executed physician and s the burial-transit	cal		_ d.							
89	ng ph as th	Physician/Medical	IE EEMALE.								
Вох	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as i	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		☐Ectopic pregnancy	,			23d. Date of de	
E	ed fo	slci	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time 9☐Unknown		Other (specify)				Month	Day Year
o O	at the	Phy	9 Unknown						2011		
ŝ,	res that the de signed by the a be detached f	þ	Part II. Dther significant conditions of	ontributing to death but no	t resulting in the t	inderlying cause giv	en in Part I.	23			o the cause of death?
oro	w require been si should b	eted							1 🗌 Yes	2010 301	obably 4 Servitown
၁ခ	has b	Completed						24	la. Was an autopsy	prior to	utopsy findings available completion of cause of
								1[performed?	death? 1 ☐ Yes	2 No
<u> </u>	Attending Physicien: Thir death. •ctor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth	26. Place of De				
ō	Phys rthis ral di	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	III JUDA	4 Nursing i		Residence escribe how inj	6 ☐Other (Spe	cify)
o	ding f th. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury	Wor	k? Yes 2 □No			,	
/ISI	or Attendi after death Director: A in by the fu	fica	3 Suicide 6 Could not b	28e. Place of Injury -	At home, farm, st	reet, factory, office					ural Route Number,
á	al or	Certification:	4 Homicide	building, etc. (S)	pecify)			Cit	ty or Town, Sta	te)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best of my	/ knowledge, dea	h occurred at the tir	ne, date and plac	e, and du	e to the cause(s) and manner as	stated.
	he H in 24 he Ft pletel	edicai	(Check only 2 Medical Exar	niner: On the basis of exa and manner stated.	immation and/or in	ivestigation, in my c	pinion, death occ	urred at th	ne time, date ar	na place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens				ate signed (Mont	
)			12/1 /h	bests mo		Doc	0632-	70	4	5/1/01	حا
	\wedge		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)					
6			Eugenia Kobertzon	, 8601 Ve	terani 1	Highway,	Suite DI	1, M	Mervil	4 MD	21108
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 2	32. Registrar's S	oignature M	Cart .					
A	inegisti	211	mai v 4 Z	UUO Jelina	10.	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAM					

Lawrence J. Forresten, Ir. 06-02897

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene UNK UNK

			Registrar	ertificate of D		nai riygiciic	Reg. No.	00	1390
	Physici al Exami		1. Decedent's Name (First, Middle,Last) Lawrence Forrester Jr.			2. Date of D Month April 29,		Year	3. Time of Death 1539 hrs
Buk Oktober	ar Exam.		4a Facility Name (if not institution, give street and number)	4b.	City, Town, or Location			nty of Death	
			5199 Raynor Drive	l t	inthicum		i i	Árundel	
	Funeral					0 86:		(YY) 9. Bir Foreig	thplace (State or
	Director		220-72-9698 1XM 2F	29 Yrs.	Months Days Hour	s Min. Feb	26 197	7 000	In Maryland
	ž		Usual Residence of Decedent 10a, State 10b, County 10c, C	City, Town or Location					10d Inside City Limits
	iow ar			Pasadena					1 Yes 2 X No
	rrylanc sa-f sh at onc	Director	10e. Street and Number		Of. Zip Code	-	10g Citizen of	What Cou	
	72 bours after death with the Maryland in "natural", or items 23a or 28a-f show any ral Examiner must be notified at once.	Dire	697 208th St.		21122		USA		,
	h with ems 23 t be no	era	11. Marital Status 1 X Never Married 2 Married Armed Forces?	1 U.S. 13. Was D	ecedent of Hispanic Or specify Cuban, Mexical	igin? (Specify Yes or I		ace - Ameri hite, etc.	ican Indian, Black,
	er deat , or it r must	Fun	3 Widowed 4 Divorced If Yes, Give Year	0	V.			_	1
	ars aft tural" tmine	ģ	15. Decedent's Education (Specify only highest grade completed	1 Ye	s 2 No specify Jsual Occupation (Give		Special 16b. Kind of	<u>.</u>	lack
"	72 hor n "na at Exa	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most	of working life. DO NO	use retired)			,
5-0036	led within 72 Hygiene other than the Medical	ם	12th 0	Stoc	k Worker		Dol1	ar G	eneral
15-0		ပ	17. Father's Name (First, Middle, Last)		i i	r's Name (First, Middle		,	
2121	uld be filed within Mental Hygiene marked other tha event, the Medic	o Be	Lawrence Forrester Sr. 19a. Informant's Name/Relationship (Type, Print)	19b Mailing A	IVI o	rsha Was			Zin Code)
MD	Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than or other traumatic event, the Medical		Sheldon Green(Brother)		8th St. I				
-	Healt Healt Fitem Fitem	1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	Db. Place of Disposition		Date	20c. Locatio	on - City or	Town, State
m e	Pages nent of ant: I			Memorial		5-8-06	Anna	poli	s, Md.
Baltimore,	permit Page Department of Important: injury or oth	Ì	21. Signature of Funeral Service Licensee	22 Nam Wm	e and Address of Facility Reese &		tuary.	P.A	
		-	Zavry B. Seese Mc0 453 23a. Part I. Enter the disease, or complications that caused the de-	1.821	West St.	Annapol	is. Md	. 21	401
	ysician Medical		failure. List only one cause on each line.		node or dying, such as	sardiac or respiratory a	irrest, shock, or	neart	Approximate Interval Between Onset and Death
Ξx	aminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) Due to (or as a consequence						Death
			Sequentially list conditions, b						
		ji	if any, leading to immediate Due to (or as a consequenc cause. Enter Underlying Cause	e of):					
	sit sd	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	e of):					
V	icate be executed physician and the burial - transit		d d			 -	_	_	
	icate be e physicia the buria	/Medical	IF FEMALE: 23c. If yes, outcome of pr	regnancy			22d Data	of delivery	
587		an/N	23b. Was decedent pregnant in the past 12 months?	2 Fetal	death 3 Ectop	c pregnancy	Month		y Day Year
Box 68	eath certif attending for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	f death 5 Other	(Specify)		}		
Э.	t the de by the ached f		Part II. Other significant conditions contributing to death but no	ot resulting in the unde	erlying cause given in P	art I. 23e. Did	tobacco use co	ntribute to	the cause of death?
P.0	ires that the signed by t	ğ				1 🗌 Y	es 2 🗸 No	3 Prob	ably 4 Unknown
rds	v requir	Completed			-	24a. Wa			topsy findings available ompletion of cause of
ဝ၁	he law ite has ige 2 s	崩				per	opsy formed? 2 No	death?	·
<u>~</u>	ysician: The l his certificate l director, page	Be C	25. Was case referred to medical		26.Place of Death		2 110	1 💓 10	s 2 No
Vita	hysicia this ca Il direc	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other	Nursing Home 5	Residence 6	Other	: Scene
۰٥	Jing Ph After t funeral		27. Manner of Death 1 Natural 5 Reading Apr 29, 2006	28b. Time of Injur 1525 hrs		Subject sh	how injury occ	urred	
sior	Attend death cctor: by the	catic	2 Accident Investigation		1 Yes 2	J NO			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined (Specify) Car	it nome, farm, street, fa	actory, office building, e	or Town,	State)		ral Route Number, City
_	Hospii 24 hour Funer ely fill		29a Certifier (Check only 1 Certifying Physician: To the best of my knowl	ledge, death occurred	at the time, date and pl		or Drive, Lir	· · · · · · · · ·	
	To the Hos within 24 h To the Fun completely	edical	one) 2 Medical Examiner: On the basis of examination and manner stated.						
	To To com	Me	29b. Signature and title of certifier		29c. License number	···	29d Date si	gned (Mor	nth, Day, Year)
			Etulh Folly us		O.C.M.E.		April 30,	2006	
	6		30. N. me and address of person who completed cause of death (It	*	4 Danie Clinia	W	04		
	ノ		Patricia Aronica-Pollak MD. Assistant Medica 31. Date filed (Month, Day, Year) 33. Registrar's Sign		1 Penn Street, B	aitimore, MD 212	U1		13
	St Regis		MAY 0 4 2006	nature	,				

		•	For State Registrar	State of	Maryland		artment of F rtificate of		nd Mental Hy	giene 0 6	13994
			1. Decedent's Name (First, Middle	e, Last)					2. Date of D		3. Time of Death
	Physicia /Medic		Jessie Mi	ldred	Foard	£			April	28, 2006	12:00 p ^M
	Examin		4a. Facility Name (If not institution	n, give street and num	rber)		4b. City, Town, o	or Location of	Death	4c. County o	
***		208	200 South Bond				Bel Ai	-		Harfo	
R .	Funeral Director		5. Social Security Number 213-14-5397 Usual Residence of Decedent	6. Sex 1 □ M 2 X F	7. Age (In yrs. ia	90 Yrs.	If Under 1 Year Months Days		Min. 8. Date of B (Month, D June 2	irth Pay, Year) 21, 1915	9. Birthplace (State or Foreign Country) Maryland
	and w		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary	ō	Maryland Harf	- Card	1	Bel Ai	1 0				1X Yes 2 ☐ No
	the 28a	Director	10e. Street and Number	OLG	1	SET HI	10f. Zip Code			10g. Citizen of W	hat Country?
	3a o		200 South Bond	l Street			2101	4		USA	
	me 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	S. 13.			n? (Specify Yes or N Puerto Rican, etc.)		- American Indian,
9	or ite	昰	1 Never Married 2 ☐ Marr	Armed Formined 1 Tes :	2 ™ No	i i			Puerto Rican, etc.)		, White, etc.
ල ල	ral'.	å by	3 Widowed 4 Divorced	Year or Da	tes:		1 ☐ Yes 2 ☐XNo	Specify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tteme 23a or 28a-f show int, it a Medical Exarti or must be rutilited at	Completed		t's Education st grade completed)		16a. Deced (Give	lent's Usual Occup kind of work done DO NDT use retire	oation during most o	of working	16b. Kind of Bus	
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2	filed v Hygie other ti	ပိ	12 17. Father's Name (First, Middle,	1 2011		Assem	bly Line	1	r s Name <i>(First, Middl</i> e	1	
Maryland	d ia b	Be			ard			Bess		Hitchco	
Ž	should Ind Mening Marke	ဥ	Jesse Billing 19a. Informant's Name/Relations		aru	10b Mailie	a Address /Ctrant		ie Ray or Rural Route Numi		
Z	d 2 sl th an 7 le r traur		B. Ruth Foard						et, Bel A		
	1 and 1 Health em 27 ther tr		20a. Method of Disposition	- SISCEI	20b. Ph				Date Date		City or Town, State
و	Pages nent of ant: If its ary or o		1 Buria 2 Cremation		itate		sition (Name of matory or other place	1	100 100		(1000)
altimore,	it. P.		4 Donation ther (S		Bel		em. Garde . Name and Addre				Maryland
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15	g by		23a. Part1. Enter the disease, or	complications that ca	used the death.						Approximate
	À		shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ich line.		,				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Key	or as a consequ		carc	TNOL	na		a weef->
	Examiner			a bus to (c	or as a consequ	erice or).					
		-	Sequentially list conditions, if any, leading to immediate	b. Dus to (c	or as a consequ	once of).					
/	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S							
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Box	es that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnan		Testania programa			23d. Date	of delivery
	deatl e atte	Cia	in the past 12 months?	4□Pregna	int at time of de]Ectopic pregnancy] Other (specify) _	у		Mont	h Day Year
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	as the	by F	Part II. Other significant condition	-		_	nderlying cause giv	en in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
ğ	w require been sig		Huperte	ension					1	Yes 2 XIII 3	B ☐ Probably 4 ☐ Unknown
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Vital	Attending Physician: The far and death. sctor: After this certificate has by the funeral director, page 2	Bec	25. Was case referred to medical examiner?					26. Place o	f Death (Check only		
<u>></u>	nyeic ais ce I dire	P	1 ☐ Yes 2 X0o	Hospital: 1 🔲 In	patient 2 E	R/Outpatier	t 3 DOA Ott	ner: 4 ☐ Nurs	ing Home 5	sidence 6 Other	(Specify)
0	ng Pl		27. Manner of Death 1 Satural 5 ☐ Pendin	28a. Date of (Month)	f Injury n, <i>Day Year)</i>	28b. Time of Injury	28c. Injui Wor	ry at rk?	28d. Describe	how injury occurre	d
0	endii eath. or: A the fu	catle	2 Accident investig	gation			M 1 🗆	Yes 2 □ No	0		
Division of	r Att	Certification:	3 ☐ Suicide 6 ☐ Could determined	inad 289. Place	of Injury - At hor g, etc. <i>(Specify)</i>	пө, farm, str)	eet, factory, office			(Street and Number own, State)	r or Rural Route Number,
٥	rs af										
)	To the Hospital or Attending Phyeician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical	g Physician: To the l Examiner: On the ba	sis of examinati	vledge, death on and/or in	n occurred at the till vestigation, in my c	me, date and popinion, death	place, and due to the occurred at the time	a cause(s) and man , date and place, ar	ner as stated. nd due to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifie	and mann	er stated.		29c. Licens				(Month, Day, Year)
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7	1		· con				100	- 10		112010	Ψ,
	6		30. Name and address of person	wno completed cause	of death (Item	23a) (Type,	6 Ha	45 5	st Bel	Harma	121014
55	Sta	tá.	31. Date filed (Month, Day, Year)	32, R	instrar's Signati		_			·	
11.00	٦ld	ar	20000	4 2006	2	100	6. 0.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#18, perFH, g855, 5/10/06 TT Department of Health and Mental Hygiene For State Registrar Amend #5 Per FH G855 5/04/06 editificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BAD **Physician** 2006. GIBSON MICHAEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Northwest Hospital Baltimore Randallstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Vre 58 May 3, 2006 Maryland Director ₩**₩. 218–46–374**3 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Owings Mills Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21117 37 S. Ritters Lane USA Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene. Int: If item 27 Is marked other then "neturel", or Items 23s Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 5. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be (UNK.) Madge Bohon Gerald Gibson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3002 McKenzie Lane, Apt. 4, York, PA 17404 Jessica Wiley/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 5/4/06 Baltimore, 1972.

22. Name and Address of Facility Cremation Society of MD, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Crensee
Fdward A. Gregorchik 299 Frederick Road Baltimore, MD 21228 Edward A Gregorchik 299 Frederick Road Baltimo:

23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) MEMMERALE /Medical Examiner SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transil orangry that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No Division of Vital To the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 Yes 2 No 2 ER/Outpatient ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 ☐ Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mella D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USEINDER PMEMTR 1405 PITIFI RAMORISTULIA CENTER MIRTHWEST 33. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 0 4 2006

DHMH 17 Rev 1/2001

ORIGINAL

Jesse Charles G	elha	ard S	Pie State of Ma						d Mental		ene			
		I- For State Registrar			Cert	ificate o	f Deat	h			Reg	. No.	2006	3996
Physicia Medical Examin	n/	Decedent's Name (First, Mic Jesse Cha:		houd							Date of Death Month I April 29, 20	Day	Year	3. Time of Death 0530 hrs
Medical Examin		4a. Facility Name (if not institu					4b. City,	Town, or	Location of D		prii 29, 20		ounty of Death	
rat		3470 Olney Laytons					Olney	/				Mor	ntgomery	
Funeral		5. Social Security Number	6. Sex		(In yrs. la	st birthday)	If Und	er 1 Yea		4Hrs. 8 Min.	Date of Birth	(MM/DD/	(YYYY) 9. Birt Foreig	hplace (State or District of
Director		216-68-0151	1 X M 2	F		47 Yr		S Day	Hours	MITT.	July 1	1, 1	958 co	untry Columbia
any	-	Usual Residence of Decedent 10a, State 10b, Count	tv		10c, City.	Town or Loca	ition							10d. Inside City Limits
p wow as			tgomery			Gaithe		^ ^						1 Yes 2 X No
arylan arylan at one	~ L	10e. Street and Number	egomery			oar the	10f. Zip				100	. Citizen	of What Cour	ntry?
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212 uld be Mente mark	To Be	19a. Informant's Name/Relation		t)		19b. Maili	ng Address	(Stree			nia Ped Route Numb		or Town, State	, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Inter: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		Virginia Gelha	ard, Mot	her		2450	Hanoy	er 1	Pike Ha	anov	er, Pe	nna.	17331	
re, land theal		20a. Method of Disposition 1 Burial 2 Cremat	ion 3 Remo	oval from Sta		lace of Disportential			metery,	Da	ate	20c. Loc	ation - City or	Town, State
Page nent o		4 Donation 5 Other		, , , , , , , , , , , , , , , , , , ,	Met	ro Cre		_		05/0	4/06	Bal	timore	, Maryland
Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signature of Funeral Servi		. (7	²² .	Name and	Addres:	s of Facility Societ	ty .0.	f Marv	land	Inc.	and 21228
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Divisior Hospital or Attend 24 hours after death Funeral Director: sely filled in by the	Certification:			ecify) Fou	und on s	idewalk				34	or Town, Sta 70 Olney L	ate) Laytons	sville Rd., (Olney, MD
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To the Hos within 24 hd To the Fun completely	Medical	2 🛡		nner_stated.	mination ar	na/or investig			n, death occur se number	red at th	e ume, date a			
	2	29b. Signature and title of cert	iner /	0	,		29		M.E.				te signed <i>(M</i> o 3, 2006	nth, Day, Year)
A .		30. Name and address of pers	complete	d cause of d	leath (Item	23a)							.,	
. 1		Zabiullah Ali, M.D.	Assistant M				nn Stree	et, Bal	timore, MD	2120	1			
St	ate	31. Date filed (Month, Day, Yes	ar)	2. Registra	r's Signatu	re Assau	2		•					

	1	For State Registrer		Cer	tificate	of D	eath	2. Date of D	Reg. No.	UU	3. Time of D	eath
Physicia		1. Decedent's Name (First, Middle, Last) HARVEY	GILLESPIE					Month 0 4	1 9 Day	2006		Рм
/Medic Examin	OF 4	sa. Facility Name (If not institution, give st Southern Marylar	reet and number) nd Hospital		4b. City, To		ocation of De	ath			eorge'	
Funeral Director		3//-42-2102	7. Age (In yrs. i 73	ast birthday) Yrs.	If Under 1 Months		If Under 24 H Hours Mi		irth 932	9. Birth Cheri	place (State or Intry) TW,SC.	-oreign
Maryland f ehow		Usual Residence of Decedent 10a. State 10b. County MD. Prince Geo		y, Town or Lo ham	cation						10d. Inside City	
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ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23s or 28e-f ehow if it then 27 is marked other then "naturel", or items 27 is marked other then "naturel".	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decede	_		(Specify Yes or N erto Rican, etc.)		Race - Amer Black, White pecify:Blace	, etc.	
ithin 72 house 19. 19. medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use net Ma	done du retired)	ion iring most of v	vorking		of Business/l	ndustry	
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nd 2 should lth and Men 27 is marke r traumatic	T ₀	19a. Informant's Name/Relationship (Type Carolyn Tidwell, Da						Rural Route Num MD. 207		Гоwп, State, Z	ip Code)	
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To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier // Certifying Physic (Check only 2 Medical Exami	sicien: To the best of my kn	owledge, dea	th occurred a	at the tim in my op	e, date and pl pinion, death o	ace, and due to the	ne cause(s) a e, date and j	and manner as place, and due	stated. to the cause(s)	
thin 2 the l	Medical	29b. Signature and the gi certifier	and manner stated.				number 5512	.D	Ann	signed (Mont	n, Day, Year)	
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			Registrar	(First Middle I	actl .		Ce	illicate of	Dealli	2. Date of D	Reg. No.	000	3. Time of Death
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سمسية	/Medic		4a. Facility Name (If n		is Gov		•	4b. City, Town, o	or Location of De		2 ,	County of Dea	
	Examin	er	11210 R				h		rville			altime	
	Funeral		5. Social Security Nur		Sex	7. Age (In yrs.			If Under 24 F	Hrs. 8. Date of B	rth	9 Bir	thplace (State or Foreign ountry)
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	p	-	Usual Residence of D 10a. State	ecedent 10b, County		10c C	ty, Town or Le	ncation					10d. Inside City Limits
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	289-1	Director	10e. Street and Numb					10f. Zip Code			10a. Citi	zen of What C	ountry?
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0	r Her	Fu	1 Never Married	XXMarried	Armed F	2 🗌 No	1			Jerto Hican, etc.)		Black, Whi	
<u> </u>	rai', o	by	3 Widowed 4	□Divorced	If Yes, G Year or I	Dates:		1□ Yes XX No	Specify:			Specify:	White
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au	B E P ♦	Be			Gover,	Sr.				h Crew			
2	should and Men marks umatic	2	19a. Informant's Nam			01.	19b. Mail	ing Address (Street			ber, City o	r Town, State.	Zip Code)
Baltimore, Maryland 21215-0036	s 1 and 2 shoul f Health and M item 27 ie marl other traumati		Betty L.	Gove	r /Wife	≘	1121	0 Ridge	way Ro	. South	ı; Lut	thervi	11e,MD2109
ō,	s 1 a f Hea item othe		20a. Method of Dispo	sition		20b.	Place of Disp	osition (Name of	ice)	Date	20c. Lo	ocation - City or	r Town, State
Ë	Pages ment of lant: If it lury or o		1 ☐ Burial 2 ☐ 4 ☐ Donation 5	Cremation 3 Other (Spe	□Removal from Enatombr	nent Ev	ergre rdens	matory or other pla en Memor Mausole	ial um 5/	/5/06	Fir	nksbur	a, MD
ä	permit. Pag Depertment important: I eny injury o		21. Signature of Fund	eral Service Lic	ensee		2	2. Name and Addre	ess of Facility E				Chapel P.A.
m	88 E 8 8		fre	de l	pp	me						ngs MI	11s,MD21117
п			23a. Part1. Enter the shock, or heart	e disease, or co failure. List on	mplications that ly one cause on	caused the dea each line.	th. Do not er	iter the mode of dy	ng, such as care	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (F disease or condition	inat		OSCUP							Onset and Death
	/Medical Examiner		resulting in death)	4	Due to	o (or as a conse	quence of):						
E	LXAIIIIICI		Sequentially list conditions if any, leading to imm	ditions,	b	. /							
	ed isit	Examiner	if any, leading to immoduse. Enter Unders Cause (Disease or in	nediate lying	Due to	o (or as a conse	quence on:						
	be executed icien and burial-transit	хап	that initiated events resulting in death) La		c	o (or as a conse	quence of):						
60,		calE		l l									
687	leath certificate ettending phys I for use as the	edic			u								
X	nding use a	Z/W	IF FEMALE: 23b. Was decedent i	pregnant		utcome of pregr						23d. Date of de	,
Ď.	death e ette	cla	in the past 12 m 1 ☐ Yes 2 ☐	nonths?	4∐Preg	binth 2 ☐ Fe gnant at time of		□Ectopic pregnand □ Other (specify) _				Month	Day Year
P.O. Box	The law requires thet the death certificat vie has been signed by the ettending phy agge 2 should be detached for use as th	Physician/Medi	9 ☐ Unknown		9□ Unk	nown							
s,	gned oe de	by P	Part II. Other signific	cant condition	s contributing to	death but not re	sulting in the	underlying cause g	ven in Part I.		_		to the cause of death?
ğ	w require been si should I									- 11/4	Yes 2	UNO 3∐F	Probably 4 Unknown
မင္	e law r has be ge 2 sh	ple								_ 24a. Wa	opsy	prior to	utopsy findings available completion of cause of
<u>~</u>	The page	Completed									formed? 2 ☑ No	death?	s 21 No
ita i	Attending Physicien: Thir deeth. ector: Atter this certificete by the funeral director, pag	Be	25. Was case referre examiner?	,	Hospitali			0		Death (Check only	-		
5	Physic this c	ဥ	1 ☐ Yes 2 ☐ ✓			Inpatient 2	28b. Time	ent 3L DOA	4 Nursi	ng Home 5 Ne 28d. Describe			ecify)
ב	Jing F	lo Lo	1 Naturat	5 Pending investiga	(Mo	onth, Day Year)	Injury	We	ork?]Yes 2∐No	Zod. Doddrio	o now inqui	,, 00001100	
<u>s</u>	or Attendester deeth Director: in by the	Ica	2 ☐ Accident 3 ☐ Suicide	6 Could no	t be	ce of tniury - At	home, farm, s	treet, factory, office		28f. Location	(Street ar	nd Number or F	Rural Route Number.
Division of Vital Records,	or A Olre	Certification:	4 🗌 Homicide	determin	ed buil	ding, etc. (Spec	eify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or T	own, State	e)	
_	To the Hospital or Attending Physicien: The within 24 hours effer deeth. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	aC						th occurred at the					
	n 24 l	edicai	(Check only)	2 Madical E		basis of exami inner stated.	nation and/or i	nvestigation, in my	opinion, death o	occurred at the time	e, date and	d place, and du	ue to the cause(s)
	To the To the Comp	ž	29b. Signature and t		1. 10			29c. Licer	nse number		29d. Da	te signed (Mor	nth, Day, Year)
	1		15	1 H.KL	bu sus			D	52065	_	5	14/06	
3	1		30. Name and addre		ho completed ca	use of death (It	em 23a) (Type	a, Print)	RX.	Ra (da)	mi	213	136
1			BRIAI 31. Date filed (Montl			Andistrar's Sin	nature —	-/4 ()					
	Sta Regist	ate rar		AY 0 4	2006	Registrar's Sig	B. A	Della D					
					2000	Or Chille in way	All and		_				

Physic		1 - State Registrar Amerid #2 F 1. Decedent's Name (First, Middle, Last Margaret)		Gibson		2. Date of Dear	h Day	2006	3. Time of Death
/Medi Examii		4a. Facility Name (If not institution, give Mercy Hospital			4b. City, Town, or Balti	more			nty of Death	
uneral irector		5. Social Security Number 6. Se 15 216-24-7358 Usual Residence of Decedent	7. Age 8.	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreig try) Md
r 28a-f ehow	Director	10a. State 10b. County Md NA 10e. Street and Number		10c. City, Town or Lo			1	0g. Citizen o	of What Count	od. Inside City Limit 1 X Yes 2 □ N try?
or other traumatic event, the Modical Examiner must be notified at	by Funeral	124 W. Franklin 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	er in U.S. 13.	21201 Was Decedent of His f Yes, specify Cubar	Specify:		14. R 8 Spec		ack
ther then "nat nt, the Madica	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 8th grade 17. Father's Name (First, Middle, Last)	cation e com <i>pleted)</i> College (1-4or 5+)	(Give	dent's Usual Occupa kind of work dene d DO NOT use retired) emaker	uring most of work	ang	Owr	Business/Ind	ustry
rked o	To Be	Howard		Gibson		Misso		naideri Sulli	Savag	je
27 ie ma er trauma		19a. Informant's Name/Relationship (7) Audrey Deane	Sister		ng Address (Street a Connally				m, State, Zip 303	
ant: If item ary or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State		sition (Name of natory or other place Mem. Pk.)	Date 7 – 06		n - City or Tov	
Important: If i any injury or	1	21. Signature of Funeral Service Licens	Wane		Name and Address		Balti 1101 E.	more, Nort	Md. :	21202
physician and disciplinate and street and st	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a of Due to (or a) Due to (or	Arrhythiconsequence of):	<u>~</u>		or respiratory arre	est,	4	Approximate Interval Between Onset and Death Sewan 1
led by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgpfns? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)				Date of deliver	'y Day Year
been signed be should be dete	þ	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause give	n in Part I.				e cause of death? Ibly 4 □Unknow
	Completed						24a. Was ar autops perform 1 Yes 2	y	prior to com death?	sy findings availab ipletion of cause of 2 \(\text{No} \)
r: After this certificate has e funeral director, page 2	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne 1 Death 1 Natural 5 Pending investigation	tospital: 1 Inpatient 28a. Date of Injury (Month, Day)	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 🗆 14013119 110	h (Check only only only only only only only only	nce 6 🗆 O)
ai Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory, office		28f. Location (Sti City or Town	eet and Nur , State)	nber or Rural	Route Number,
9 =	ledical	one) 2 Medical Exami	sician: To the best of ner: On the basis or e and manner state	xamination and/or inv	restigation, in my opi	nion, death occur	and due to the ca red at the time, da	use(s) and a te and place	manner as sta e, and due to	ited. the cause(s)
the Fu	Σ	29b. Signature and title of certifier	. 2	M	29c. License	number	25	-	ned (Month, D	* '
To the Funeral Director: After completely filled in by the funer		30. Name and address of person who co	3					/ 1		C5 - 6

State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 30, 2006 Year **Physician** Ann Elizabeth Grotheer 9:55 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 181 Codjus Drive Rising Sun Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Aug. 1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□ F 122-24-0467 74 New York Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-1 show any njury or other traumatic event, the Medical Exeminary. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2,☐ No Md. Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 181 Codius Drive 21911 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry post office Elementary/Secondary (0-12) Coflege (1-4or 5+) clerk 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Pfalzer Ruth C. Wicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Grotheer/husband 181 Codjus Drive, Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 XRemoval from State 5/3/06 Maple Grove Cem. Kew Gardens, N.Y. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preprovascular Accident Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Obstructive Pulmonary Disease Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Alterosclerosis attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ certificate has been signi rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 1 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cholen 5 M D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SSachologonal (ISN orth SF 118North Sacholoumi 31. Date filed (Month, Day, Year) 32. egistrar's Signature State MAY 0 4 2006 Registrar